HennepinHealthcare

# Hennepin Care Application

| ADULT 1 Head of Household or Guarantor Information | | | | | | |
|---|---|---|---|---|---|---|
| Patient Name | Social Security # | | Date of Birth ___/___/___ | | Medical Record # | |
| Address | Apt # | City | | State **MN** | Zip Code | |
| Telephone Number | County of Residence | Marital Status | Are you applying for Hennepin Care Discount | | YES<br>NO | |

| ADULT 2 Legal Spouse or Parent of Child under 18 | | | | | | |
|---|---|---|---|---|---|---|
| Spouse Name | Social Security # | | Date of Birth ___/___/___ | | Medical Record # | |
| Address | Apt # | City | | State **MN** | Zip Code | |
| Telephone Number | County of Residence | Marital Status | Are you applying for Hennepin Care Discount | | YES ☐<br>NO ☐ | |

## Children under 18 living in your Household

Biological Children & Stepchildren (legally your dependents)

| Last Name | First Name | D.O.B | Relationship | MRN | Applying for Henn Care Discount? YES | NO |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Is everyone applying a U.S citizen or U.S National? ☐ YES ☐ NO - Fill in below

| Last Name | First Name | Immigration Status | Date entered the U.S |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Employment/Work History - Adult 1

Please include all employment information for the past 30 days. Submit 1 month of pay stubs.
If you need additional space, please use back of application or attach on separate paper.

| Employer's name | Address<br>Telephone # | Start Date:<br>End Date: | $ Hourly Rate | Hours per Week | How Often Paid |
|---|---|---|---|---|---|
| Do you receive tips? | ☐ NO ☐ YES - Enter Monthly Amount $ | | | | |
| Employer's name | Address<br>Telephone # | Start Date:<br>End Date: | $ Hourly Rate | Hours per Week | How Often Paid |
| Do you recive Tips? | ☐ NO ☐ YES - Enter Monthly Amount $ | | | | |

## Employment/Work History - Adult 2

If you're married, you must also provide your spouse' employment information for the past 30 days

| Employer's name | Address<br><br>Telephone # | Start Date:<br><br>End Date: | $ Hourly Rate | Hours per Week | How Often Paid |
|---|---|---|---|---|---|
| Do you receive tips? ☐ NO ☐ YES - Enter Monthly Amount $ | | | | | |
| Employer's name | Address<br><br>Telephone # | Start Date:<br><br>End Date: | $ Hourly Rate | Hours per Week | How Often Paid |
| Do you receive tips? ☐ NO ☐ YES - Enter Monthly Amount $ | | | | | |

## Other Income

Please submit appropiate documentation with your completed application

| Child Support: | Monthly Amt<br>$ | Unemployment: | Monthly Amt<br>$ |
|---|---|---|---|
| Self-Employment Income Self: | Monthly Amt<br>$ | Alimony: | Monthly Amt<br>$ |
| Self Employment Income Spouse: | Monthly Amt<br>$ | Social Security: | Monthly Amt<br>$ |
| Other Income: | Monthly Amt<br>$ | Other Income: | Monthly Amt<br>$ |

If no income has been reported, explain in the box below how you pay for your living expenses such as food, housing, clothing and other things you need.

## Liquid Assets

Please submit copies your most recent complete bank statement.

| Name of Bank: | Account Type: | Owner(s) Name: | Current Balance: |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| Cash | | | $ |
| Value of Stocks/Bonds | | | $ |
| Value of Certificates of Deposit | | | $ |
| Value of Money Market Accounts | | | $ |

# CERTIFICATION

1.- I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2.- I will apply for any and all assistance that may be available to help pay this bill.
3.- I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., financial institution and credit grantors of any kind to disclose to any authorized agent of Hennepin County Medical Center information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize Hennepin County Medical Center to perform a credit check for both responsible persons/patient and spouse
4.- I understand that I might be asked to provide documentation to verify my information.

| | |
|---|---|
| Signature (Patient/ Guarantor) | Date: ____ / ____ / ____ |
| Signature (Spouse) | Date: ____ / ____ / ____ |

## DIRECTIONS FOR COMPLETING THE HENNEPIN CARE APPLICATION

**Personal Information:**

1. Complete the Head of Household name, social security number, date of birth, and medical record number if known.
2. Complete the same information for Adult 2 (Legal Spouse or Parent of Child under 18).
3. Complete the responsible person's address, County of Residence, home telephone number, and other telephone number such as cell phone.
4. Mark the appropriate box if applying for Hennepin Care Discount.

**Household Information:**

1. List the name, date of birth, relationship, and appropriate box if applying for Hennepin Care Discount of each dependent in the household.

**Citizenship Information**

1. Complete the appropriate fields pertaining to your status in the United States for everyone applying.

**Employment/Work History - Self:**

1. Complete the employer information for the Head of Household (Adult 1). Please complete the name of all employers within the last six months, the employer's address and telephone number.
2. Complete the hourly (or salary) rate and the # of hours worked per week. Please indicate if TIPS are received; if so, list amount.
3. If there was no employment, please indicate "Not Employed" in the Company Name box.
4. Include a copy last year's tax return and/or 1 month of pay stubs.

**Employment/Work History – Spouse:**

1. If married, please complete the employer information for the spouse (Adult 2). Please complete the name of all employers within the last six months, the employer's address and telephone number.

2. Complete the hourly (or salary) rate and the # of hours worked per week. Please indicate if TIPS are received; if so, list amount.

3. If the spouse was not employed, please indicate "Not Employed" in the Company Name box.

4. Include a copy last year's tax return and/or 1 month of pay stubs.

### Other Income:

1. Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits.

### No Income

1. If no income is reported, please explain, in the box provided, how you pay for your living expenses such as food, housing, clothing and other expenses.

### Liquid Assets:

1. Complete the banking information section by listing the name of your bank or financial institution, account type (checking or savings account), owner(s) name and the current balance in each account.

2. Complete the Other Assets section by indicating the value of any Cash, Certificates of Deposit, Stocks/Bonds or Money Market Accounts. If there are no additional assets, please mark "N/A".

3. Include a copy of your most recent bank statement(s) and, if applicable, document(s) showing value of other liquid assets.

**DOCUMENTATION:** Please notice that your signature indicates you have agreed to attach all income verification. If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We

### WHAT YOU ARE AGREEING TO:

1. Stating that the responsible persons/patient has completed this form accurately.

2. Stating that the responsible persons/patient will apply for any assistance to pay this bill. If the responsible persons/patient has sufficient debt capacity, the responsible persons/patient may be expected to acquire a bank loan or pay for their services with a credit card.

3. Authorizing Name of Health Care System to obtain credit information and perform a credit check.

# Hennepin Care Application

**HEAD OF HOUSEHOLD INFORMATION**
(PLEASE PRINT)

| Last Name | First Name | MI | Date Of Birth<br>_____/_____<br>Month Day |
|---|---|---|---|
| Address | Apt# | City | |
| Telephone Number<br>( ) | Mailing address if different then the one listed | | |
| Are You Employed<br>☐ Yes ☐ NO | Do you have Medical Insurance?<br>☐ Yes ☐ NO | Is Medical Insurance offered a<br>☐ Yes ☐ NO | |
| Are you a citizen?<br>(optional)<br>☐ YES<br>☐ NO | Check your race(optional) ☐African, ☐Hispanic/Latino, ☐ Black/African American,<br>☐ American Indian/Aleutian, Eskimo,<br>☐ Asian, Pacific Islander, ☐ White, ☐Other | Preferred spoken language? | |

Today's Date

☐**M**ale

☐**F**emale

_/_____

Year

**MN**

Zip Code

at work?

Are you applying for Assured Access

☐ **YES** ☐ **NO**