Financial Assistance Application

Astera Health

I hereby request that Astera Health determine my eligibility for financial assistance. I understand that the information that I submit for my annual income, family size and assets is subject to verification by Astera Health. I also understand that if the information I submit is determined to be false, such a determination will result in a denial of providing uncompensated services and that I will be liable for the charges for services provided.

Name:	
Birthdate:	SS#:
Address:	
City/State/ZIP:	
Phone:	
Employer:	

Spouse:	
Spouse Birthdate:	SS#:
Spouse Phone:	
Spouse Employer:	

***TOTAL FAMILY SIZE:**

List Below All Members of Household Beginning with Patient					
Name	Age	Birthdate	Name	Age	Birthdate

*Family size of one is denoted as a person 15 years of age or older who is not living with any relatives. Family units of size greater than one include only persons related by birth, marriage or adoption, who reside together. Students younger than age 26, regardless of residence who are supported by parents or others related by blood, marriage or adoption are considered to be residing with those who support them. One hundred percent forgiveness for applicable services is obtained at 200% of the most-recent Federal Poverty Guidelines. Fifty percent forgiveness for applicable services is obtained at 250% of the Federal Poverty Guidelines.

FAMILY SIZE	ANNUAL INCOME GUIDELINES 100%	ANNUAL INCOME GUIDELINES 50%
1	$31,920	$39,900
2	$43,280	$54,100
3	$54,640	$68,300
4	$66,000	$82,500
5	$77,360	$96,700
6	$88,720	$110,900
7	$100,080	$125,100
8	$111,440	$139,300

For family units with more than eight members, add $11,360 for each additional member.
Add $14,200 for 50% for families over 8.

	Patient	Spouse	Other
Wages (Gross)	$	$	$
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			

Government Assistance			
Disability Payments			
Dividends/Interest			
Other, List			
MONTHLY INCOME SUBTOTAL			
TOTAL INCOME: $	MONTHLY: $	YEARLY: $	

HOUSEHOLD ASSETS	VALUE
Savings (attach copy)	$
Checking (attach copy)	
Stocks and Bonds	
Mutual funds, Money Market, etc.	
Cash Value of Life Insurance	
Real Estate Value (non-homestead)	
Vehicles Value (not including primary)	
Jewelry & Other Personal Property	
Other Assets (Describe)	
Total Household Assets:	$

Household Debts	Payment	Balance
Home Loan	$	$
Auto Loan	$	$
Credit Card Debt	$	$
Other:	$	$
Total Household Debts:	$	$

Other Pertinent Information Regarding Financial Situation

*Assets are not considered for forgiveness of clinic balances and can be skipped if applying for clinic bills only. (Assets are not considered for NHSC Program.)

Medical Assistance

County applied _____ Date applied _____

Approved/Denied _____ Copy of letter attached ☐Yes ☐No

I understand that the information that I submit is subject to verification by Astera Health and subject to review and final determination by the Financial Assistance Committee within 60 days of satisfactory completion/application. I certify that the information submitted is true and correct:

SIGNATURE:	**DATE:**

While always encouraged, application for Medical Assistance is required only for forgiveness of hospital based services. For forgiveness of clinic bills only, record of approval/denial of medical assistance is not required.

Astera Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Astera Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.

Financial Assistance Application Checklist

As Part of the Financial Assistance Application process we will need you to send information to verify your income and assets as it applies to your household.

The following information is required and must be included with your completed application. The application should be returned within 30 days or Astera Health will proceed with collection activity on all accounts under the assumption that the patient has declined to apply. Applications will still be accepted after the 30 days with no penalty.

Federal and State Tax Return	Did you file taxes last year?	☐Yes ☐No	If Yes, include your current tax return.
Employment Income	Is anyone in your household employed?	☐Yes ☐No	If Yes, send the last 3 months of paystubs for all employed household members.
Unemployment Income	Is anyone in your household receiving unemployment income?	☐Yes ☐No	If Yes, send the current unemployment award letter.
Social Security/ Disability Income	Is anyone in your household receiving Social Security/Disability income?	☐Yes ☐No	If Yes, send the current award letter.
Child Support/Alimony	Does anyone in your household receive Child Support or Alimony payments?	☐Yes ☐No	If Yes, send proof of deposits.
Bank Accounts	Does anyone in your household have a checking or savings account?	☐Yes ☐No	If Yes, send the last 3 months of statements for all bank accounts. **Hospital Services Only**
Investments	Does anyone in your household have investments? (stocks, bonds, mutual funds, money markets)	☐Yes ☐No	If Yes, send current investment statements that can be accessed with no early withdrawal penalty. **Hospital Services Only**
Non-Homesteaded Property	Does anyone in your household own any non-homesteaded property?	☐Yes ☐No	If Yes, send current property tax statement for non-homesteaded property. **Hospital Services Only**
MA/MNCare	Have you applied for MA or MNCare with your county of residence?	☐Yes ☐No	As part of our application process you will need to apply if you have not. Please send proof of your county's determination. **Hospital Services Only**
Life Insurance	Does anyone in your household have life insurance that has a cash value?	☐Yes ☐No	If Yes, send current statement showing value if no early withdrawal penalty would apply. **Hospital Services Only**

*Please remember to sign and date the application. If you have any questions or need help filling out the application please contact us.

Thank you,
Patient Financial Advocates, Phone: 218-631-7498, Email: PFA@asterahealth.org, Fax: 218-631-7595