



Queen of Peace Hospital

*Bringing Medical Excellence Home*



WOMEN'S  
HEALTH  
CENTER

Queen of Peace Hospital



Southern Metro Medical Clinics

Belle Plaine • Le Sueur • Montgomery • New Prague

301 Second Street NE, New Prague 952.758.4431

Date: \_\_\_\_\_

Dear Patient:

Queen of Peace Hospital, recognizing the growing costs of healthcare and the effect that unexpected health claims may have on already limited household finances, has implemented a Community Assistance Program. This financial assistance program was created to assist individuals in paying for their health care services at Queen of Peace Hospital, Women's Health Center and Southern Metro Medical Clinics.

Financial assistance determinations are awarded on a per case basis and are based upon your completed Community Assistance Application along with required supporting documentation, family size and household income. We have attached a copy of the Community Assistance Application. Please read it carefully and complete all the requested information. If you do not have access to a copier, you may bring in your original supporting documentation when submitting your completed application and we will be happy to make the copies for you. In order to address your financial assistance in a timely fashion, we ask that you submit the completed application and supporting documentation to our business office by \_\_\_\_\_.

If you have any questions regarding our Community Assistance Program and the attached application, please feel free to contact Jenn or Ann in our Business Office at (952) 758-8121 or (800) 584-6667, extension 5421.

Thank you.

If you have any questions or concerns regarding our collection policies contact Paula Nelson, CFO, (952) 758-8103 or (800) 584-6667 or you have the option to address any concerns with the Minnesota Attorney General's office, which can be reached at (651) 296-3353 or (800) 657-3787.

Queen of Peace offers a Charity Care Program to our patients who qualify. Patients are eligible for charity care if family income is less than 200% and we also use a sliding scale discount up to 400% of the most recently published Federal Poverty Guidelines, or due to medical or financial hardship. If patients are determined to be ineligible for any governmental program, our Business Office Staff will assist the patient with the completion of a Charity Care application. Charity Care is available only for self-pay balances, including deductibles and co-insurance of governmental programs and third party insurance coverage.

200% Poverty Level Guidelines (as published in the Federal Register 1-23-2009) for family size:

(1) 21,660.00 (2) 29,140.00 (3) 36,620.00 (4) 44,100.00 (5) 51,580.00 (6) 59,060.00 (7) 66,540.00 (8) 74,020.00

# Queen of Peace Hospital Application for Community Assistance

Checklist of **REQUIRED** information: (copies only- no originals)

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Most recent Income Tax return<br><input checked="" type="checkbox"/> Letter of explanation of your situation<br><input checked="" type="checkbox"/> Proof of student status (if applicable)<br><input checked="" type="checkbox"/> Medical Assistance Denial (if you have not applied, you must explain why)<br><input checked="" type="checkbox"/> Complete listing of all outstanding medical debt (other hospitals/clinics) | <input checked="" type="checkbox"/> Proof of income for most recent 3 months<br><input checked="" type="checkbox"/> Copy of most recent bank statement<br><input checked="" type="checkbox"/> Monthly prescription drug cost (summary from pharmacy) |
|--|--|

**Please Note:**  
**This application cannot be processed without the above documentation.**

Last Name	First Name	MI	Home Phone #	Cell Phone #
Address	City	State		Zip Code
Occupation	Employer	Spouses Occupation	Spouses Employer	

**Family size** (number of dependants)

Name	DOB	Relationship	Name	DOB	Relat.
_____	_____	self	_____	_____	child
_____	_____	spouse/partner	_____	_____	child
_____	_____	child	_____	_____	child
_____	_____	child	_____	_____	child

**Total Household Income**

Wages/Salary	\$ _____
Wages from Self-employment	\$ _____
Wages from Unemployment	\$ _____
Social Security Benefits	\$ _____
Veterans Benefits	\$ _____
Employer Pension	\$ _____
Rent/Contract for Deed	\$ _____
All other income	\$ _____
Child Support	\$ _____
<b>TOTAL</b>	<b>\$ _____</b>

**Total Assets**

Checking Account(s)	\$ _____
Savings Account(s) (IRA, 401K)	\$ _____
Certificates of Deposit	\$ _____
Stocks, Bonds, Mutual Funds	\$ _____
Homestead Value	\$ _____
Other Property Value	\$ _____
Cash Value Life Insurance	\$ _____
<b>TOTAL</b>	<b>\$ _____</b>

**Have you ever declared bankruptcy?**    \_\_\_\_\_ Yes    \_\_\_\_\_ No

**Do you have any judgments or liens filed against you? If yes, please describe:** \_\_\_\_\_  
 \_\_\_\_\_

**What is the approximate amount of other medical bills you owe?** \_\_\_\_\_

**How much of your medical bills are you able to pay:**\$ \_\_\_\_\_

**Please inform us of any additional information you would like us to consider with your application.**

(Attach separate paper listing any circumstances you would like us to take into consideration)

If you have an outstanding medical bill with the following providers, check the box:

<input type="checkbox"/>	Allina
<input type="checkbox"/>	Consulting Radiologist
<input type="checkbox"/>	Fairview
<input type="checkbox"/>	Minnesota Gastroenterolgy

**Total Monthly Expenses**

	Monthly	Outstanding
Bank Loan Payment(s)	\$ _____	\$ _____
Credit Card Payment(s)	\$ _____	\$ _____
House Payment	\$ _____	\$ _____
Rent Payment	\$ _____	\$ _____
Car/Truck Payment(s)	\$ _____	\$ _____
All Insurance Payment(s)	\$ _____	\$ _____
Child Support/Daycare	\$ _____	\$ _____
Utilities		
Phone	\$ _____	\$ _____
Cable	\$ _____	\$ _____
Internet	\$ _____	\$ _____
Electricity	\$ _____	\$ _____
Water	\$ _____	\$ _____
Gas	\$ _____	\$ _____
Medical Bills	\$ _____	\$ _____
Prescriptions	\$ _____	\$ _____
Others (please specify)		
\$ _____	\$ _____	
\$ _____	\$ _____	
<b>Total Monthly Expenses:</b>	<b>\$ _____</b>	<b>\$ _____</b>

Queen of Peace Hospital provides service to anyone in need of healthcare, regardless of race, creed, national origin or financial ability.

**ASSIGNMENT OF RIGHTS - Read Carefully**

By signing below I certify that the information and statements contained in this Application for Community Assistance and the supporting documentation which I submit is accurate, true and correct to the best of my knowledge. I understand that Queen of Peace may make reasonable requests for additional information and verification if necessary.

I understand that the information and statements I have provided will be kept confidential by Queen of Peace.

I understand that I have the obligation to provide complete and truthful information to Queen of Peace, and to cooperate with any of Queen of Peace's requests for verification and additional information. I understand that completion of this application will allow Queen of Peace to consider my circumstances, and Queen of Peace makes no representations that financial assistance is guaranteed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date