Financial Assistance Program and Petersen Patient Care Fund

Olmsted Medical Center Financial Assistance Program

Olmsted Medical Center is pleased to offer our OMC Financial Assistance Program. This program is available to Minnesota residents who are uninsured or underinsured and unable to pay for their medical services that are considered medically necessary. Eligibility is determined by measuring household income and/or assets against current guidelines.

OMC also offers the Petersen Patient Care Fund. If you are eligible, your application will be considered for that fund in addition to the Financial Assistance Program.

Carl and Ihla Petersen Care Fund

The Carl and Ihla Petersen Patient Care Fund has been established by the OMC Regional Foundation through the generosity of the late Carl Petersen in honor of his wife Ihla. In establishing a perpetual trust to support this fund, Mr. Petersen wished to help individuals and families living in Olmsted County who, through no fault of their own, are unable to pay for the medical care they need at Olmsted Medical Center. The Petersen Patient Care Fund does not replace Medical Assistance or other commercial and third party insurers.

If you feel you may be eligible for financial assistance, please complete and return the application along with copies of information requested. If you would like to speak to someone for more information, please contact Olmsted Medical Center at 507.287.2780.

When the application is completed, please return to **Olmsted Medical Center, PO Box 4300, Rochester, MN 55903.**

If you qualify for assistance from OMC's Financial Assistance Program and/or OMC Regional Foundation's Petersen Patient Care Fund, you will be notified by the OMC Business Office. In the future, should your financial circumstances change, we invite you to consider a gift to the OMC Regional Foundation in order to support financial assistance to other patients in need. Thank you.

Clinic Account #: ____

Hospital Account #: ______________________________________

Name on Account: ____

Please return completed application to OMC within 10 days.

Please print

Guarantor's Name: ______________________________________ ______________________________ _____

(Last name) (First name) (MI)

SS#: ____________________________ Date of Birth: _____/_____/________ Sex: _____

Street address: _____________________________________ City: __________________ State:_____ Zip: __________

E-mail Address: _____________________ Marital Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

Home Phone: ________________________ Number of children under 18 years old living full-time in the household? _____

Are you a Minnesota Resident? ❑ Yes or ❑ No (mark one) What county do you live in? ___________________________

Employer Name: ____ How long employed: ___________________

Gross Salary (monthly): ______________________

If unemployed – Last date of employment: ________________ Is unemployment seasonal: ❑ Yes or ❑ No (mark one)

Spouse's Name: ______________________________________ ______________________________ _____

(Last name) (First name) (MI)

SS#: ____________________________ Date of Birth: _____/_____/________ Sex: _____

Employer Name: ____ How long employed: ___________________

Gross Salary (monthly): ______________________

If unemployed – Last date of employment: ________________ Is unemployment seasonal: ❑ Yes or ❑ No (mark one)

Additional Income: ❑ Social Security ❑ Pension ❑ Disability ❑ Child Support ❑ Public Assistance
❑ Other ____

Bank Account: (where)___________________________ Checking Bal.: $____________ Savings Bal.: $_____________

HOME: ❑ Own, Mortgage Holder____ Monthly Payment: $_____________

Market Value: $_______________ Mortgage Balance: $_______________ Original Amount: $_____________

❑ Rent. Monthly Rent: $_______________

CARS: ❑ Own ❑ Financed Monthly Payments: $ 1. _________________________ 2. _________________________

Balance due: $ 1. ________ 2.________ Year and Make of Car(s) 1. _________________ 2. _________________

MONTHLY EXPENSES:			
	$___________ Telephone/Cell	$___________ Food	$___________ Cable
	$___________ Heat	$___________ Water/Sewer	$___________ Car – gas/maintenance
	$___________ Electric	$___________ Property Taxes	$___________ Other (specify): ______

INSURANCE PAYMENT: Life: $___________ Health: $___________ Auto: $_____________

OUTSTANDING DEBTS WITH BANKS, DEPARTMENT STORES, OR OTHER FINANCIAL INSTITUTIONS

	Name and Address of Creditor	Original Balance	Monthly Payment	Balance Due
(1)	____	_______________	_______________	_______________
(2)	____	_______________	_______________	_______________
(3)	____	_______________	_______________	_______________
(4)	____	_______________	_______________	_______________

I certify that all information given in this application to OMC is true and correct to the best of my knowledge. I authorize the release of the required information to OMC, and I authorize OMC to verify any information submitted on this application, including the request of my credit report, if necessary. Please be aware that OMC will review the information you have given in conjunction with your credit report to verify the debts listed.

Required

____
Applicant Signature Date

Required

____
Co-Applicant Signature (Spouse/Significant Other). Date

Required

____
Dependant Signature (any child 18 years or older living at home) Date

____
OMC Patient Accounts Staff Signature Date

____
Patient Accounts Supervisor Signature Date

The following information is required

❑ **Copies of the last 3 months (90 days) pay stubs for all members of the household; including any unemployment, child support, Public Assistance, or Social Security benefits received (required)**

Reason for excluding required information ______________________________

❑ **Most current Income Tax Return (Including all supporting tax schedules) (required)**

Reason for excluding required information ______________________________

❑ **Most recent banking statements (checking and savings); be sure to send complete bank statements (required)**

Reason for excluding required information ______________________________

❑ **Current year's Property Tax forms (required)**

Reason for excluding required information ______________________________

❑ **Proof of amount still owed for Home Loan (bank statement or letter from bank) (required)**

Reason for excluding required information ______________________________

❑ **Proof of Minnesota resident; proof can be one of the following: (required)**

- **Copy Minnesota Driver's license with picture**
- **Copy Minnesota ID Card with picture**

Reason for excluding required information ______________________________

When application is complete, mail to:

Olmsted Medical Center
PO Box 4300
Rochester, MN 55903

Translated Versions – Consent – Financial Assistance Program and Petersen Patient Care Fund Application
English – 2050306 Spanish – 2030410