Ortonville Area Health Services

ORTONVILLE AREA HEALTH SERVICES

Financial Assistance Application

Need help paying your OAHS bill? You may qualify for a full or partial discount, or a limit on charges. You may apply within 240 days of your first billing statement. Help completing this form is free: 320-839-4096 or pfs@oahs.us.

1) Applicant / Household Information

Applicant Name	**Family Size #**	**Date Application Given**	
Co-Applicant Name	**Adults #**	**Email**	
Address	**Children/Dependents #**		
City / State / ZIP	**Total Household Size**		
Home Phone	**Cell Phone**		
Primary Language	**Need help completing? ☐ Yes**		

2) Quick Qualify — If Any Box Applies, Attach Proof and Skip to Signature Below

☐ Medical Assistance (MA), MinnesotaCare, or other Medicaid program	☐ Homeless or shelter housing
☐ Deceased patient with no estate / no responsible guarantor	☐ Prior OAHS Financial Assistance approval in past 12 months; situation unchanged

Proof attached: ☐ MA/MNcare card/letter ☐ Prior FAP letter ☐ Death/no estate proof

3) Household Income — Monthly Amounts (skip if Section 2 applies)

Gross wages - applicant	$	**Gross wages - co-applicant**	$
Social Security / disability	$	**Unemployment / workers comp**	$
Child support / alimony	$	**Pension / retirement income**	$
Rental / investment income	$	**Public assistance / other**	$
Other:	$	**Other**	$
TOTAL MONTHLY HOUSEHOLD INCOME	**$**		

4) Countable Liquid Assets (skip if Section 2 applies)

Include only: checking, savings, CDs, money market, and non-retirement investments. Do NOT count primary residence, retirement accounts (401k/403b/IRA/pension), HSA, personal vehicles, household goods, or personal effects.

Checking balance	$	**Savings balance**	$
CD / money market	$	**Non-retirement investments**	$
Other countable liquid assets	$	**TOTAL COUNTABLE LIQUID ASSETS**	**$**
Notes / N/A if none			

5) Documentation Checklist

Income Documentation — attach ONE:

☐ Most recent federal tax return
☐ Two most recent pay stubs
☐ Social Security benefit letter
☐ Unemployment benefit letter
☐ Proof of public program enrollment (MA, MinnesotaCare, SNAP, WIC, TANF, MFIP, SSI)

Asset Documentation requested:

☐ Two most recent checking statements
☐ Two most recent savings statements
☐ Most recent non-retirement investment statement(s)
☐ CD or money market statement(s)
☐ Not applicable; do not resend documents already provided

6) Optional Referral to Other Coverage Programs

OAHS can refer you to a MNsure-certified navigator / Certified Application Counselor at no charge if you may qualify for Medical Assistance, MinnesotaCare, or premium tax credits. Applying for a program you are not reasonably eligible for is not required.

☐ Yes, please refer me ☐ No thank you

7) Signature and Attestation

By signing below, I state that the information on this application is true and accurate to the best of my knowledge. I understand OAHS may request reasonable additional documentation to verify eligibility. False information may result in denial or reversal of Financial Assistance.

Applicant Signature	**Printed Name**	Date:
Co-Applicant Signature (if any)	**Printed Name**	Date:

Patient Rights / Important Notices

OAHS will not deny medically necessary care because of unpaid medical bills; will not report medical debt to credit bureaus; will not add interest or late fees; and will not automatically transfer medical debt to your spouse.

AGB Cap: If you are FAP-eligible or uninsured with household income under $125,000, OAHS automatically limits charges for emergency/medically necessary care to Amounts Generally Billed (AGB).

Return to: OAHS Patient Financial Services, 450 Eastvold Avenue, Ortonville, MN 56278 | Phone 320-839-4096 | pfs@oahs.us | www.oahs.us