

## **Mille Lacs Health System Financial Aid Programs**

Mille Lacs Health System will bill all insurance companies for our patients. We offer financial aid programs to help pay the balance that is your responsibility after insurance pays/denies, or if you have no insurance. **Please contact our Patient Account Representative for more details on these programs.**

**\* Charity Care Program -**

The federal poverty income guidelines provide the initial framework to determine an individual's ability to pay. Factors to consider include: family size, income, and cost of providing shelter, food, utilities, etc. If you qualify for this program, the balance is either discounted or the entire balance is adjusted, based on a sliding fee schedule.

**\* Uninsured Patient Program -**

If you have no insurance, you may qualify for this discount program. Eligible patients or the responsible party need to complete an application for the uninsured discount. If Mille Lacs Health System determines a patient **does** have insurance, we will reverse the uninsured discount and bill the insurance for the full amount.

**\* Payment Programs -**

**Cash Discount:**

We offer a 10% discount if you pay the balance that is your responsibility within 30 days of your first statement.

**Payment Option:**

If you are unable to pay the balance in one payment, our Patient Account Representative will offer a reasonable payment plan.

**If you have any questions, please contact Sandy Johnson at (877) 535-3154, ext. 2649, or (320) 532-2649.**



P.O. Box A  
200 North Elm Street  
Onamia, MN 56359  
320-532-3154

## **Uninsured Patient Discount Program**

Patients without insurance and whose annual household income is less than \$125,000 may qualify for a discount through our Uninsured Patient Program. The discount is valid on uninsured admissions for one year after the date an application is completed with Mille Lacs Health System.

The uninsured discount is for charges billed directly by Mille Lacs Health System only, and does not include any charges or fees that may be incurred from outside physicians, specialists, radiologists, or labs.

If Mille Lacs Health System determines a patient does have insurance, the uninsured discount will be reversed and the insurance will be billed for the full amount.

In some cases, patients who have a major medical plan with a high deductible may qualify for the uninsured discount.

If you would like more information regarding this program or have any questions, please contact Sandy Johnson at 320-532-2649 or 1-877-535-3154, ext. 2649.

**MILLE LACS HEALTH SYSTEM  
P O BOX A  
ONAMIA MN 56359  
REQUEST FOR FINANCIAL ASSISTANCE**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR PATIENT ACCOUNT REPRESENTATIVE, SANDY JOHNSON, AT 1-877-535-3154, ext. 2649, or (320) 532-2649.**

Date of Application: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK: \_\_\_\_\_

**FAMILY INFORMATION:** Please list name and age of all persons living in household. If persons are over 18 please indicate if student and/or working.

(Section 1)

NAME	RELATIONSHIP	AGE

(Section 2)

**INCOME INFORMATION:**

- Please provide a copy of the most current Tax Return.

	<b>Self</b>	<b>Spouse</b>	<b>Others</b>
<b>Gross Monthly Income:</b>	\$ _____	\$ _____	\$ _____

**Any other income not included above, such as: child support, Social Security, pensions, etc.  
Please list below.**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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\*\*\*\*\*If you are not applying for the Charity Care program, do not fill out section 3\*\*\*\*\*

(Section 3)

In order to qualify for the Charity Care program, you must apply for Medical Assistance in your county first.

Have you applied for Medical Assistance with your county? Yes\_\_\_ No\_\_\_ (please check one)

If No, you must do so.

If Yes, what was the outcome? (If denied, attach copy of denial)\_\_\_\_\_

(Section 4)

**MONTHLY EXPENSES:**

House: Own Rent (Circle one) \$\_\_\_\_\_ Electric: \$\_\_\_\_\_

Heat/Gas \$\_\_\_\_\_ Phone: \$\_\_\_\_\_

Food \$\_\_\_\_\_ Car Loan \$\_\_\_\_\_

Insurance Premiums \$\_\_\_\_\_ Charge Acct Balance \$\_\_\_\_\_

Child Care: Alimony payments Day Care (Circle One) \$\_\_\_\_\_

Other Medical Expenses: \_\_\_\_\_

Other Financial Obligations \_\_\_\_\_

(Section 5)

**CREDIT ACCOUNTS:**

CHECKING BANK: \_\_\_\_\_

BALANCE: \_\_\_\_\_

SAVINGS BANK: \_\_\_\_\_

BALANCE: \_\_\_\_\_

CD'S BANK: \_\_\_\_\_

BALANCE: \_\_\_\_\_

<b>ASSETS:</b>	Land	Property	Vehicles	Other
Value:	\$_____	\$_____	\$_____	\$_____

(Section 6)

**APPLICANT'S COMMENTS: Please tell why you need to file this form, or other information that will help us make a determination on this account**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Do not write below this line

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Adjustment % Approved \_\_\_\_\_ Adjustment Amt. Approved \_\_\_\_\_

DOS Covered \_\_\_\_\_ to \_\_\_\_\_ Applicants Share still owing \$ \_\_\_\_\_

Applicant to pay \$ \_\_\_\_\_ Month \$ \_\_\_\_\_ Lump Sum \$ \_\_\_\_\_

Comments:

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Approved By: \_\_\_\_\_ Denied By \_\_\_\_\_