301 Highway 65 South
Mora, MN 55051
320-679-1212

WELIA CARE INSTRUCTIONS AND CHECKLIST

To process your application, supporting documentation is required to determine your eligibility for the program. Failure to supply required documentation will result in a delay of the application process. Please note the following:

1. **If you only have Medicare (A&B), you MUST apply for Seven County Senior Federation first.**
2. **You must have a qualifying balance of $250 or greater with Welia Health hospital or clinic to apply.**
3. **If approved, you will be responsible for a $15 clinic copay and a $30 emergency services copay.**

Please note, the Welia Care does not provide coverage for all medical expenses, only those charged/billed by Welia Health.

Requirement	Explanation	Completed
Completed and signed application	• Application/Financial Worksheet must be fully completed • Application/Financial Worksheet must be signed and dated by applicants	❑
Insurance Information	• Attach proof of current health insurance for all family members • Attach written denials from Medical Assistance, MNCare <u>and</u> MNSure *If current applicant has current healthcare coverage, no denial is needed* • If Medical Assistance denial indicates you may qualify for MNCare, attach the MNCare denial • Attach a statement indicating spend down amount	❑
Proof of liquid asset balance	• Attach copies of your most recent bank statements for all checking, savings and health saving accounts. Include history with <u>all</u> pages.	❑
Proof of income	• If applicants have no income a shelter statement must be completed <u>If employed</u>: • Attach copies of your four most recent pay stubs or an employer statement listing two months of pay • Attach a copy of current state and federal tax returns. Include all pages. <u>If unemployed</u>: • Attach a copy of unemployment benefits • Attach a copy of current state and federal tax returns. Include all pages.	❑
Dependent inclusion	• Dependents over the age of 18 will only be considered in family size calculation if they are included on tax return	❑

If you do not have access to a copier, bring your documents with you and we will assist you. If you have any questions, please call the Welia Health business office at 320-225-3340.

WELIA CARE APPLICATION

Applicant Information		
Your name:		
Social Security Number:		Date of birth:
Spouse name:		
Social Security Number:		Date of birth:
Address:		City:
State:	Zip:	Phone:
Dependent Children or Other(s)		
Name:		
Social Security Number:		Date of birth:
Name:		
Social Security Number:		Date of birth:
Name:		
Social Security Number:		Date of birth:
Name:		
Social Security Number:		Date of birth:
Name:		
Social Security Number:		Date of birth:

Employment				
Self:	❑ Employed*	❑ Self-employed	❑ Unemployed	❑ Retired
Spouse:	❑ Employed*	❑ Self-employed	❑ Unemployed	❑ Retired

Medical Insurance	
Insurance company:	Insurance policy #:
Medicaid #:	Medicare #:
Spouse, Dependents and Other(s)	
Name:	
Insurance company:	Insurance policy #:
Name:	
Insurance company:	Insurance policy #:
Name:	
Insurance company:	Insurance policy #:
Name:	
Insurance company:	Insurance policy #:
Name:	
Insurance company:	Insurance policy #:

*Based on your income, we will ask you to apply for Medical Assistance. If the patient has an insurance deductible/co-pay, and falls within the income guidelines, these individuals may still qualify for Welia Care. If you only have Medicare (A&B), you must also apply for Seven County Senior Federation.

WELIA CARE FINANCIAL WORKSHEET

Monthly Income		
Please complete your current monthly income.	Self	Spouse
Gross wages or salary		
Self-employment		
Interest income		
Dividends or capital gains		
Social Security benefits or disability benefits		
Employee/employer pension		
Veteran's benefits		
Income from rent, lease, or contract for deed		
All other income (child support, etc.)		
Total Monthly Income:		

Bank Information	
Please attach your bank statement(s).	
Bank name:	
Savings balance:	Checking balance:
Bank name:	
Savings balance:	Checking balance:
Total value of liquid assets:	
HSA bank name:	Balance:

Healthcare Facilities
Name of clinic you usually use:
Name of hospital you usually use:

To process your Welia Care application, supporting documentation is required to determine your eligibility for the program. Failure to supply required documentation will result in a delay of the application process.

I/we certify that the information on this application is true and correct.

Patient Signature ____________________ Date/Time ____________________

Spouse Signature ____________________ Date/Time ____________________

WELIA CARE SHELTER STATEMENT

This document is required for applicants who state they are not currently employed and have no other source of income. This document is to be completed by the person or persons who provide food and shelter to this applicant.

_________________________________ lives with me at:
Applicant Name

____
Address

_________________________________ ____________ ______________
City State Zip

He/she is currently unemployed. I (Provider) provide his/her means of support.

_________________________________ ____________________________
Provider Signature Date/Time

____
Provider name (please print)

____
Provider relationship to applicant

____
Provider telephone number

_________________________________ ____________________________
Witness* Signature Date/Time

____
Witness name (please print)

** Witness must be a third party, not applicant or supporter.*