WeliaCare Application
Instructions and Checklist

To process your application for Welia Health's WeliaCare Program, we will need supporting documentation to determine your eligibility for the program. Failure to supply the required documentation will result in a delay of the application process or denial. Please note the following:

Check when complete	Required documentation	Explanation
☐	Completed and signed application	• Financial/Application worksheet must be fully completed (fill in all sections) • Application must be signed and dated by applicants
☐	Insurance information	• Proof of current health insurance for all family members • Written denials from Medical Assistance, MNCare and MNSure *(If current applicant has current healthcare coverage, no denial is needed.)* • If MA denial indicates you may qualify for MNCare, please include MNCare denial. • Statement indicating spenddown amount
☐	Proof of liquid asset balance	• Copies of most recent bank statements for all checking, savings and health saving accounts *(Include history with all pages.) Do not black out information.* • Copies of CDs, money market account and/or stock/bonds statements

Check when complete	Required documentation	Explanation
☐	Proof of income	If applicants have no income a shelter statement must be completed. **If Employed** • Copies of four (4) most recent pay stubs or employer statement listing two (2) months of pay, **AND** • Current State and Federal tax returns *(Include all pages)* **If Unemployed** • A copy of the unemployment benefits, **AND** • Current State and Federal tax returns *(Include all pages)* **If Retired** • A copy of your social security annual award letter
☐	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 photocopy machine, bring your documents with you and we will assist you with your photocopies.

If you have any questions, please call the Welia Health business office at 320.225.3340.

WeliaCare Application
Application/Financial Worksheet
Please complete all sections

Applicant Information		
Your Name:		
Social Security #:		Birthdate:
Spouse:		
Spouse Social Security #:		Birthdate:
Address:		City:
State:	Zip Code:	Phone:
Dependent Children or Other(s)		
Name:		
Social Security #:		Birthdate:
Name:		
Social Security #:		Birthdate:
Name:		
Social Security #:		Birthdate:
Name:		
Social Security #:		Birthdate:
Name:		
Social Security #:		Birthdate:

Employment Information				
Patient:	*Employed** ☐	*Self-Employed* ☐	*Unemployed* ☐	*Retired* ☐
Spouse:	*Employed** ☐	*Self-Employed* ☐	*Unemployed* ☐	*Retired* ☐

Medical Insurance Information	
Insurance Company:	Policy #:
Medicare #:	Medicaid #:
Spouse, Dependent Children or Other(s)	
Name:	
Insurance Company:	Policy#:
Name:	
Insurance Company:	Policy#:
Name:	
Insurance Company:	Policy#:
Name:	
Insurance Company:	Policy#:
Name:	
Insurance Company:	Policy#:

* Based on your income, we may 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 the WeliaCare Program. If you only have Medicare (A&B), we encourage you to apply for Seven County Senior Federation.

MONTHLY INCOME *Please list 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 pensions or ***annuities***		
Veteran’s benefits		
Income from rent, lease, or contract for deed		
Unemployment		
All other income (child support, etc.)		
Total Monthly Income:		

BANK INFORMATION *Please attach your bank statement(s). Do not black out information.*	
Bank name:	
Savings balance:	Checking balance:
Bank name:	
Savings balance:	Checking balance:
Total value of liquid assets:	
Health Savings Account Bank Name:	Balance:

HEALTHCARE FACILITIES
Name of the clinic you usually use:
Name of the hospital you usually use:

The WeliaCare Program does not provide coverage for all medical expenses, only those charged/billed by Welia Health.

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

Your Signature: ___________________________________ Date: ___________________

Spouse Signature: ________________________________ Date: ___________________

Shelter Statement

This document is required for WeliaCare Program 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 provide his/her means of support.

_______________________________ _______________

Provider Signature Date

____

Provider Name (*please print)*

____

Provider Relationship to Applicant

____

Provider Telephone Number

* _______________________________ _______________

Witness Signature Date

____

Name (*please print)*

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

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