Sioux Center Health
An Avera Partner

1101 9th St SE
Sioux Center, IA 51250
(712) 722-8445

**ATTACHMENT I** **CONFIDENTIAL**

**Sioux Center Health**
**Financial Assistance Application & Patient Financial Information**

This form is to provide information to assist you in satisfying your financial obligation to Sioux Center Health.

Applicant Name ___________________________ Spouse or Significant Other Name ___________

Current Address ___________________________ Renting ______Buying _____ Years lived at ___

City __________________State____Zip_______ Home Telephone _________________________

Marital Status: S M D W Sep Other

Applicant Social Security # __________________ Spouse Social Security # __________________

Applicant Birth Date _______________________ Spouse Birth Date _______________________

Please list dependents: (attach separate sheet if necessary)

**Name** **Date of Birth** **Relationship** **Name** **Date of Birth** **Relationship**

________________________________________ ________________________________________

________________________________________ ________________________________________

________________________________________ ________________________________________

Applicant Employer ________________________ Spouse or Sig. Other Employer _____________

Position _______________Years Employed ___ Position ______________Years Employed ___

Have you applied for Medicaid? Yes _____ No ______If not, why?_____________________

Please note: Applicants that have not applied for Medicaid and or other potential financial assistance programs, before completing this application for Financial Assistance, may be asked to do so. If you have any questions regarding financial assistance or information required on this application, please contact the Billing Office at Sioux Center Health at 712-722-8297 or 712-722-8183. Please return your completed application, along with supporting documentation, to the Business Office of the Avera location where you received service.

Supporting Documentation, please provide the most recent*:

- ❑ W-2(s)
- ❑ Tax Return (Federal, State if applicable)
- ❑ Pay Stub(s)
- ❑ Bank Statement(s)
- ❑ Financial Statements

*The Business Office may request additional information if necessary.

**By submitting this assistance application, I understand that the Avera organization receiving this application may share it and related documentation with other Avera organizations that are involved with my treatment or may have provided separate treatment.**

| Monthly Household Income | Applicant | Spouse |
|---|---|---|
| Employment (Gross/Net Pay) | $_______________ | $_____________ |
| Social Security/Disability | $_______________ | $_____________ |
| Retirement/Veteran Pension (all sources) | $_______________ | $_____________ |
| Unemployment Comp. | $_______________ | $_____________ |
| ADC/WIC/Food Stamps | $_______________ | $_____________ |
| Alimony/Child Support | $_______________ | $_____________ |
| Investment/Interest Income | $_______________ | $_____________ |
| Other (List___________) | $_______________ | $_____________ |
| **Total Monthly Income** | $_______________ | $_____________ |
| **Net Monthly Income** | $_______________ | $_____________ |
| **Total Income last 12 months** | $_______________ | $_____________ |

**Copy of Tax Return and last 2 month's pay stubs are required**.

| Monthly Household Expenses | Applicant/Spouse |
|---|---|
| Rent/Mortgage | $_______________ |
| Food | $_______________ |
| Car Payments | $_______________ |
| Child Care | $_______________ |
| Transportation/car expense | $_______________ |
| Medical/Dental* | $_______________ |
| Insurance (car, medical, etc..) | $_______________ |
| Credit Card (__________) | $_______________ |
| Collection Agencies | $_______________ |
| Clothing | $_______________ |
| Other (List___________) | $_______________ |
| **Total Monthly Expenses** | $_______________ |

| ASSETS (Current market value) | | |
|---|---|---|
| Cash on hand/Bank/Savings (Please provide statements) | | $_____________ |
| Investments/CD's (Market value) | | $_____________ |
| Loan/Cash value of Life Insurance | | $_____________ |
| Residence: sq. ft. total ____________ | | |
| Purchase Price | $_____________ | |
| Estimated Value Now | | $_____________ |
| Vehicle: Year/Model _______________________ | | $_____________ |
| Vehicle: Year/Model _______________________ | | $_____________ |
| Farm Real Estate: # of acres ____________ | | $_____________ |
| *Farm Equipment | | $_____________ |
| *Livestock | | $_____________ |
| *Rental Property | | $_____________ |
| *Business | | $_____________ |
| Other ___________________ | | $_____________ |
| | **Total Assets** | $_____________ |

| LIABILITIES (Current Balance) | |
|---|---|
| Medical Bill* ___________ | $_______________ |
| Medical Bill *___________ | $_______________ |
| Medical Bill *___________ | $_______________ |
| Credit Card(s) | $_______________ |
| Loan on furniture & Appliances | $_______________ |
| Home Loan | $_______________ |
| Vehicle Loan | $_______________ |
| Real Estate Loan | $_______________ |
| Amount owed on farm equip. | $_______________ |
| Amount owed on livestock | $_______________ |
| Loan on Rental Property | $_______________ |
| Loan on Business | $_______________ |
| Amount owed on other | $_______________ |
| Amt owed to Collection Agency | $_______________ |
| **Total Liabilities** | $_______________ |

* For Farmers and Business owners, please provide that latest bank prepared balance sheet and cash flow.
* * Out-of Pocket Expense or Liability only (net of any insurance, discounts, third party liability, or any other potential claim)

Were you offered health insurance from your employer? _____Yes ____No
Were you denied health insurance by your employer? _____Yes ____No

Are you eligible for COBRA benefits? _____Yes ____No

I hereby acknowledge that the information given to Avera is true and correct. I authorize Avera to verify any of the information given by me. I will provide documentation of this information upon request.

Signed ____________________________ Date ______________

Signed ____________________________ Date ______________

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INTERNAL USE ONLY

Points____________ Full_____Partial______

Approved ____________________ Date ____________ Denied_____Date ___________

Approved by: ________________________________________ Denied By: ________________