

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)

Table with 6 columns: Name, Age, Relationship, Name, Age, Relationship. It contains three rows of blank lines for entering dependent information.

Applicant Employer _____ Spouse or Sig. Other Employer _____

Position _____ Years Employed _____ Position _____ Years Employed _____

Have you applied for or do you have Medicaid coverage? Yes _____ No _____ If not, why? _____

Are you currently a student? Yes _____ No _____

If you are under the age of 26 does your parent's employer offer healthcare coverage for you? Yes _____ No _____

Applicants should apply for Medicaid and any other potential financial assistance programs before completing this application for Financial Assistance. If you are a resident of South Dakota, you must also apply for County Poor Relief before applying for Financial Assistance. If you have any questions regarding financial assistance or information required on this application, please contact the Financial Counselors at Sioux Center Health, 712-722-8297.

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/Other Household Members	Monthly Household Expenses	Applicant/Spouse/Other Household Members
Employment (Gross/Net Pay)	\$ _____	\$ _____	Rent/Mortgage	\$ _____
Social Security/Disability Retirement/Veteran Pension (all sources)	\$ _____	\$ _____	Food	\$ _____
Unemployment Comp.	\$ _____	\$ _____	Car Payments	\$ _____
ADC/WIC/Food Stamps	\$ _____	\$ _____	Child Care	\$ _____
Alimony/Child Support	\$ _____	\$ _____	Transportation/car expense	\$ _____
Investment/Interest Income	\$ _____	\$ _____	Medical/Dental*	\$ _____
Other (List _____)	\$ _____	\$ _____	Insurance (car, medical, etc.)	\$ _____
Total Monthly Income	\$ _____	\$ _____	Credit Card (_____)	\$ _____
Net Monthly Income	\$ _____	\$ _____	Collection Agencies	\$ _____
Total Income last 12 months	\$ _____	\$ _____	Clothing	\$ _____
Copy of Tax Return and last 2 months pay stubs are required.			Other (List _____)	\$ _____
			Total Monthly Expenses	\$ _____

ASSETS (Current market value)

Cash on hand/Bank/Savings	\$ _____
Investments/CD's (Market value)	\$ _____
Loan/Cash value of Life Insurance	\$ _____
Residence: sq. ft. total _____	_____
Purchase Price	\$ _____
Estimated Value Now	\$ _____
Primary Vehicle: Year/Model _____	\$ _____
Vehicle: Year/Model _____	\$ _____
Farm Real Estate: # of acres _____	\$ _____
Farm Equipment	\$ _____
Livestock	\$ _____
Rental Property	\$ _____
Business	\$ _____
Other _____	\$ _____
Total Assets	\$ _____

LIABILITIES

Medical Bill* _____	\$ _____
Medical Bill * _____	\$ _____
Medical Bill * _____	\$ _____
Credit Card(s)	\$ _____
Loan on furniture & Appliances	\$ _____
Home Loan (current balance)	\$ _____
Vehicle Loan (current balance)	\$ _____
Real Estate Loan (current balance)	\$ _____
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	\$ _____

* 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
 Have you applied for insurance via the insurance exchange? ___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 _____

INTERNAL USE ONLY

Points _____ Full ___ Partial _____

Approved _____ Date _____ Denied _____ Date _____

Approved by: _____ Denied By: _____