ATTACHMENT I **CONFIDENTIAL**

Avera Financial Assistance Application &
Patient Financial Information

Please return with the most recent copies of your W-2, tax return, pay stubs and bank statements. Failure to provide those documents will result in processing delays or an application denial.

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	**Age**	**Relationship**	**Name**	**Age**	**Relationship**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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 Patient Accounts Manager at Avera (organization), (phone number).

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	$_____	$_____	Food	$_____
Retirement/Veteran Pension (all sources)	$_____	$_____	Car Payments	$_____
Unemployment Comp.	$_____	$_____	Child Care	$_____
ADC/WIC/Food Stamps	$_____	$_____	Transportation/car expense	$_____
Alimony/Child Support	$_____	$_____	Medical/Dental*	$_____
Investment/Interest Income	$_____	$_____	Insurance (car, medical, etc..)	$_____
Other (List_____)	$_____	$_____	Credit Card (_____)	$_____
Total Monthly Income	$_____	$_____	Collection Agencies	$_____
Net Monthly Income	$_____	$_____	Clothing	$_____
Total Income last 12 months	$_____	$_____	Other (List_____)	$_____
Copy of Tax Return and last 2 months pay stubs are required.			**Total Monthly Expenses**	$_____

ASSETS (Current market value)			**LIABILITIES**	
Cash on hand/Bank/Savings		$_____	Medical Bill* _____	$_____
Investments/CD's (Market value)		$_____	Medical Bill *_____	$_____
Loan/Cash value of Life Insurance		$_____	Medical Bill *_____	$_____
Residence: sq. ft. total _____			Credit Card(s)	$_____
Purchase Price	$_____		Loan on furniture & Appliances	$_____
Estimated Value Now		$_____	Home Loan (current balance)	$_____
Primary Vehicle: Year/Model _____		$_____	Vehicle Loan (current balance)	$_____
Vehicle: Year/Model _____		$_____	Real Estate Loan (current balance)	$_____
Farm Real Estate: # of acres _____		$_____	Amount owed on farm equip.	$_____
Farm Equipment		$_____	Amount owed on livestock	$_____
Livestock		$_____	Loan on Rental Property	$_____
Rental Property		$_____	Loan on Business	$_____
Business		$_____	Amount owed on other	$_____
Other _____		$_____	Amt owed to Collection Agency	$_____
	Total Assets	$_____	**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 Health Insurance through the health Insurance exchange program? ____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: _____

ATTACHMENT II

(Healthcare Facility)

CONSENT TO RELEASE OF INFORMATION TO COUNTY OF RESIDENCE

I, the undersigned, understand that I will receive or have received the above healthcare facility and at the time of treatment, I either have/had no insurance coverage, and/or am not aware of any insurance coverage, commercial or otherwise, to which the healthcare organization may submit claims on my behalf for the purpose of obtaining payment and/or related benefits for my healthcare treatment. I also affirm that I am not eligible for Indian Health Service benefits nor am I a member of a Native American tribe and thus Indian Health Services and/or the Bureau of Indian Affairs are not potential resources for the hospital to submit claims for my healthcare treatment on my behalf. I also affirm that I have not served in any branch of the military for any period of time, or if I have served in a branch of the military, the healthcare that I am receiving is not eligible or covered by the Veteran's Administration.

I understand that I may or may not have the personal financial resources to pay the costs for healthcare treatment and care as recommended by my attending/treating physician and as such, this form is being signed by me to authorize all persons, agencies, or institutions (including this healthcare organization and my physician(s)) to release to the welfare director, auditor, states attorney, and/or county commissioners of my county of residence, information concerning my social security number, medical information concerning my healthcare treatment, and financial information concerning me and/or members of my household. This information will be required by my county of residence to process benefits on my behalf for which I may be eligible.

By signing, I indicate that I fully understand this Consent to Release of Information, and am voluntarily signing below.

Dated this _____day of _____, year.

_____	_____
*Patient Social Security Number	*County of Residence
_____	_____
*Patient	Patient Representative
_____	_____
*Witness	Witness
_____	
*Account #	*Required

ATTACHMENT III

Avera Health
Financial Assistance Application
Presumptive Eligibility

Patient Name: _____ Patient SSN: _____

Patient Date of Birth: _____ Patient Account Number: _____

Eligibility Criteria that may be considered:

Initial if Yes	**Reason for Eligibility**
	Homeless or received care from a homeless clinic
	No income
	Participation in Women's, Infant's and Children's programs (WIC)
	Food stamp eligibility
	Subsidized school lunch program eligibility
	Eligibility for other state or local assistance programs that are un-funded (e.g Medicaid spend-down)
	Family or friends of the patient have provided information establishing the household's inability to pay
	Low income/subsidized housing is provided as a valid address
	Patient is deceased with no known estate
	Patient/Grantor is incarcerated, has no assets and is not eligible for parole within the next 18 months.
	Other (Describe):

Verification

Attach documentation or written attestations demonstrating eligibility

Submitters Signature:_____ Date: _____

Print Submitters Name: _____ Title: _____