**Attachment I**

Platte Health Center - Avera
Patient Assistant Application &
Financial Information

This form is to provide information to assist you in satisfying your financial obligation to **Platte Health Center - Avera.**

Applicant Name _____ Spouse 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 # _____

__ Over 65 __ Blind ___Permanently Disabled _ Over 65 __ Blind ___Permanently Disabled

_____Date of Disability Determination _____Date of Disability Determination

Applicant Birth Date _____ Spouse Birth Date _____

Former Address _____ City _____State____Zip_____
(If under 3 years at current)

Dependent children under 18 years old living in your household: (attach separate sheet if necessary)

| **Name** | **Age** | **Relationship** | **Name** | **Age** | **Relationship** |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Applicant Employer _____ Spouse Employer _____

Position _____ Years Employed ___ Position _____ Years Employed ___

If employed less than 3 years at current employer, please complete the following:

Applicant Former Employer _____ Spouse Former Employer _____

Insurance Information:

Health Insurance Provider _____ Group # _____

Insurance Subscriber # _____ Policy Owner _____

Medicare # _____ Medicaid # _____

Applicants should first apply for Medicaid 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 either program or information required on this application, please contact the Business Office at Platte Health Center - Avera, (605) 337-3364.

Please return your completed application, along with supporting documentation, to the Platte Health Center Business Office. Supporting Documentation, please provide the most recent*:

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

*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** | **Monthly Household Expenses** | **Applicant/Spouse** |
|---|---|---|---|---|
| Employment (Gross/Net Pay) | $_____ | $_____ | Rent/Mortgage | $_____ |
| Part-Time Jobs (Gross/Net) | $_____ | $_____ | Food | $_____ |
| Social Security/Disability | $_____ | $_____ | Utilities | $_____ |
| Veteran Pension | $_____ | $_____ | Car Payments | $_____ |
| Retirement (all sources) | $_____ | $_____ | Child Care | $_____ |
| Unemployment Comp. | $_____ | $_____ | Transportation/car expense | $_____ |
| Workers Comp. | $_____ | $_____ | Medical/Dental | $_____ |
| Union Benefits | $_____ | $_____ | Insurance **(car, medical, etc..)** | $_____ |
| Inheritance | $_____ | $_____ | Credit Card (_____) | $_____ |
| ADC/WIC/Food Stamps | $_____ | $_____ | Credit Card (_____) | $_____ |
| Alimony/Child Support | $_____ | $_____ | Collection Agencies | $_____ |
| Savings Interest Income | $_____ | $_____ | Clothing | $_____ |
| Investment Income | $_____ | $_____ | Other (List_____) | $_____ |
| Other (List_____) | $_____ | $_____ | Other (List_____) | $_____ |
| | | | | $_____ |
| **Total Monthly Income** | $_____ | $_____ | **Total Monthly Expenses** | $_____ |
| **Net Monthly Income** | $_____ | $_____ | | |
| **Total Income last 12 months** | $_____ | $_____ | | |
| **Total Income last 3 months** | $_____ | $_____ | | |

PLEASE NOTE: Copy of most recent Tax Return and last 2 months pay stubs are required.

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

Have you applied for Medicaid or other government assistance programs? ___Yes ___No

Do you have a balance due at any other Avera facility? _____Yes _____No If Yes, amount owed. $_____

I hereby verify that the information given to PHC is true and correct. I authorize PHC to verify any of the information given by me. I will provide documentation of this information upon request. I understand that the information which I submit concerning my annual income and family size is subject to verification by PHC. I also understand that if the information which I submit is determined to be false, it will result in a denial of Patient Assistance status and that I will be liable for charges for services provided.

Signed _____ Date _____

Signed _____ Date _____

---

INTERNAL USE ONLY

Approved _____ Amount_____ Date _____ Denied____ Date _____

For Admission Dated _____ to _____ Explain _____

Applicant's Share $_____ ___WK ____MO

$_____ Lump Sum

Income Verified _____ Type of Verification _____

Approved by: _____ Denied By: _____