Avera Financial Assistance Application
and Patient Financial Information

This form is to provide information to assist you in satisfying your financial obligation to 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 Patient Accounts Manager at Avera (organization), (phone number).

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 provide proof of income. Acceptable proof includes tax returns and/or paycheck stubs.

ASSETS (Current market value)			LIABILITIES	
Cash on hand/Bank/Savings		$____________	Medical Bill ___________	$______________
Investments/CD's (Market value)		$____________	Medical Bill ___________	$______________
Loans to Others		$____________	Medical Bill ___________	$______________
Loan/Cash value of Life Insurance		$____________	Credit Card(s)	$______________
Furniture & Appliances		$____________	Loan on furniture & Appliances	$______________
Residence: sq. ft. total ___________				$______________
Purchase Price	$____________			$______________
Improvements	$____________			$______________
Estimated Value Now		$____________	Home Loan	$______________
Vehicle: Year/Model ______________________		$____________	Vehicle Loan	$______________
Vehicle: Year/Model ______________________		$____________	Vehicle Loan	$______________
Farm Real Estate: # of acres ____________		$____________	Real Estate Loan	$______________
Farm Equipment		$____________	Amount owed on farm equip.	$______________
Livestock		$____________	Amount owed on livestock	$______________
Rental Property		$____________	Loan on Rental Property	$______________
Business		$____________	Loan on Business	$______________
Inheritance/settlement pending		$____________	Amount owed on other	$______________
Other __________________		$____________	Amt owed to Collection Agency	$______________
	Total Assets	$____________	**Total Liabilities**	$______________

Bank Name ___________________________ Checking Account #_____________ Balance $__________

Address ______________________________ Savings Account #______________ Balance $__________

Telephone Number ____________________

Bank Name ___________________________ Checking Account #_____________ Balance $__________

Address ______________________________ Savings Account #______________ Balance $__________

Telephone Number ____________________

Name of Contract/Mortgage Holder ____

Name of Landlord ________________________ Address ________________________ Phone__________

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 Avera (organization) is true and correct. I authorize Avera (organization) 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 Avera (organization). I also understand that if the information which I submit is determined to be false, it will result in a denial of charity care 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: ________________