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 # _____

Applicant Birth Date _____ Spouse Birth Date _____

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 ___

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 Pay)	$_____	$_____	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	$_____	$_____		

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

Assets			Liabilities	
Cash on Hand/Bank/Savings		$_____	Medical Bill	$_____
Investments/CDs (market value)		$_____	Medical Bill	$_____
Loan/Cash Value of Life Insurance		$_____	Medical Bill	$_____
Residence: square footage	_____	$_____	Credit Card(s)	$_____
Purchase Price	$_____		Loan on Furniture/Appliances	$_____
Estimated Current Value		$_____	Home Loan (current balance)	$_____
Primary Vehicle: Make/Model	_____	$_____	Vehicle Loan (current balance)	$_____
Vehicle: Make/Model	_____	$_____	Vehicle Loan (current balance)	$_____
Farm Real Estate: Number of Acres	_____	$_____	Amount Owed on Real Estate	$_____
Farm Equipment		$_____	Amount Owed on Farm Equip.	$_____
Livestock		$_____	Amount Owed on Livestock	$_____
Rental Property		$_____	Loan on Rental Property	$_____
Business		$_____	Loan on Business	$_____
Other (List_____)		$_____	Other on Other (_____)	$_____
Total Assets		$_____	**Total Liabilities**	$_____

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 Health Insurance through the health insurance exchange program? ____Yes ____No
Have you applied for Medicaid or other government assistance programs? ____Yes ____No
Are you currently a student? ____Yes ____No
If you are under the age of 26 does your parents employer offer healthcare coverage for you? ____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.

Signed _____ Date _____

Signed _____ Date _____

INTERNAL USE ONLY

Points_____ Full_____ Partial_____

Approved _____ Amount_____ Date _____ Denied_____ Date _____

Approved by: _____ Denied By: _____