

Landmann - Jungman Memorial Hospital Avera  
600 Billars Street  
Scotland, SD 57059

[www.avera.org/scotland](http://www.avera.org/scotland)

Dear Patient,

Thank you for choosing Landmann-Jungman Memorial Hospital Avera/Scotland Medical Clinic for all of your health care needs. In the spirit of Charity and Justice, we exist in response to God's calling for a healing ministry to the sick, the elderly and the oppressed and to provide health services to all persons in need, without regard to the consideration of race, sex, creed, national origin or ability to pay.

Applicants should exhaust all other resources include State and Federal programs, before applying for financial assistance.

In order to review your eligibility for financial assistance we will need the enclosed application along with income verification returned before we can proceed.

**Please return the following information to the address noted on this letter:**

1. Application (Enclosed)
2. Copy of most recent income tax return (balance sheet required if agriculture/business)
3. Copies of earnings and bank statements for the last two months
4. Please provide any other related information you think could help us in determining your eligibility

By providing all documentation you may be eligible for financial assistance to cover all or a portion of your expenses.

**Failure to complete or include these items will result in a returned or denied application.**

If the documents are not returned within 14 business days from the date indicated on this letter, **further collection activities will resume**. Upon receipt of your application and the required documents, a prompt decision will be made on your eligibility for financial assistance. You will be notified via mail as soon as decision has been made. Please call 605-583-2226 with any questions.

Sincerely,

Landmann-Jungman Memorial Hospital  
Attn: Financial Assistance  
600 Billars Street  
Scotland, SD 57059  
Phone: 605-583-2226 Fax: 605-583-4557  
[ljbilling@ljmh.org](mailto:ljbilling@ljmh.org)

**Landmann-Jungman Memorial Hospital Financial Assistance Application**

Date of Service: \_\_\_\_\_ Account Number: \_\_\_\_\_ Applicant Name(s): \_\_\_\_\_

**If patient is under 18, we need both parents' information and documents.**

<b>PRIMARY APPLICANT</b>			
LAST NAME (print)	FIRST NAME (print)	DATE OF BIRTH	
SOCIAL SECURITY NUMBER	MY CONTACT PHONE NUMBER	<input type="checkbox"/> Mobile	<input type="checkbox"/> Landline
		<input type="checkbox"/> Business	<input type="checkbox"/> Message
STREET ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE

<b>SPOUSE/PARTNER</b>			
LAST NAME / FIRST NAME (print)	DATE OF BIRTH	RELATIONSHIP TO PRIMARY APPLICANT	
		<input type="checkbox"/> Spouse	<input type="checkbox"/> Significant Other
		<input type="checkbox"/> Household Member	
SOCIAL SECURITY NUMBER	MY CONTACT PHONE NUMBER	<input type="checkbox"/> Mobile	<input type="checkbox"/> Landline
		<input type="checkbox"/> Business	<input type="checkbox"/> Message
STREET ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE

<b>HOUSEHOLD INCOME INFORMATION</b>			
<b>Supporting Documents Needed: 3 mo Current and All Consecutive Pay Stubs</b>			
EMPLOYER NAME PRINT (Responsible Party)	CITY	WORK PHONE	MONTHLY *GROSS INCOME
EMPLOYER NAME PRINT (Spouse)	CITY	WORK PHONE	MONTHLY *GROSS INCOME

\*Gross = before taxes or deductions

**Dependents (if more than 4 dependents use separate page)**

Full Name	Relationship	Birth Date (mm-dd-yyyy)
1.		
2.		
3.		
4.		

Homeless or received care from a homeless clinic? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Subsidized school lunch program eligible? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food Stamps/WIC Eligible? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eligible for other state or local assistance programs? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is Patient/Guarantor Incarcerated? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you have no reported income, how are you being supported? Explain Below:		
Low income/subsidized housing eligible? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Patient/Guarantor is deceased with no estate? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		

**FOR INCOME/ASSETS LISTED, YOU MUST PROVIDE THE FOLLOWING FOR EACH MEMBER OF THE HOUSEHOLD:**

- |   |   |
|---|---|
| <input type="checkbox"/> Employment – 2 Months Pay Stubs          | <input type="checkbox"/> Child Support – Verification of Payments Received (Last 12 Months) |
| <input type="checkbox"/> Unemployment – Benefit Letter            | <input type="checkbox"/> Bank Statements – ALL Checking/Savings Accounts (Last 2 Months)    |
| <input type="checkbox"/> Social Security/Pension – Benefit Letter | <input type="checkbox"/> Last Pay Stub from Any Other Jobs in the Current Year              |
| <input type="checkbox"/> Tax Return – Form 1040 and ALL Schedules | <input type="checkbox"/> Other:   |

**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.**

Primary Applicant (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse/Partner (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this application and supporting documentation within 14 days of receipt:  
Mail to LJMHS 600 Billars Street, Scotland, SD 57059 - Email to [ljmbilling@ljmh.org](mailto:ljmbilling@ljmh.org)