**ATTACHMENT I** **CONFIDENTIAL**

**Eureka Community Health Services Avera and/or**
**Eureka Medical Clinic Avera**
**Sliding Fee Discount Application**

This form is to provide information to assist you in satisfying your financial obligation to Eureka Community Health Services Avera and/or Eureka Medical Clinic Avera. This discount will apply to all services received at this hospital and/or clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if you financial situation changes.

Applicant Name _____

Current Address _____

City _____State____Zip_____

Home Telephone _____

Renting _____ Buying _____ Years lived at ___

Applicant Social Security # _____

Applicant Birth Date _____

Marital Status: S M D W Sep Other

Spouse or Significant Other Name _____

Spouse Social Security # _____

Spouse Birth Date _____

Spouse Phone # _____

Please list dependents: (attach separate sheet if necessary)

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

Applicant Employer _____

Position _____ Years Employed ___

Spouse or Sig. Other Employer _____

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 _____

If you have any questions regarding financial assistance or information required on this application, please contact the business office at Eureka Community Health Services Avera or Eureka Medical Clinic Avera.

**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** |
|---|---|---|
| Employment (Gross/Net Pay) | $_____ | $_____ |
| Social Security/Disability Retirement/Veteran Pension (all sources) | $_____ | $_____ |
| Unemployment Comp. | $_____ | $_____ |
| ADC/WIC/Food Stamps | $_____ | $_____ |
| Alimony/Child Support | $_____ | $_____ |
| Investment/Interest Income | $_____ | $_____ |
| Other (List_____) | $_____ | $_____ |
| **Total Monthly Income** | $_____ | $_____ |
| **Net Monthly Income Total Income last 12 months** | $_____ | $_____ |

**Copy of Tax Return and last 2 months pay stubs are required.**

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 _____

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INTERNAL USE ONLY

Patient Name:_____

Approved Discount _____

Approved by:_____

Date Approved: _____

**Here is the website to view our Financial Assistance Policy:**

**https://www.avera.org/app/files/public/f2b3f8ac-26bc-4fdb-ab1b-c17fe4ec06e4/Eureka%20Financial%20Assistance%20Policy%202024.pdf**