CONFIDENTIAL

COMMUNITY MEMORIAL HOSPITAL

Financial Assistance Application &
Patient Financial Information

This form is to provide information to assist you in satisfying your financial obligation to Community Memorial Hospital.

Applicant Name: _____

Spouse or Significant Other Name: _____

Current Address: _____

City: _____State:_____Zip: _____

Renting:_____ Buying:_____Years lived at current address: _____

Home Telephone: _____ Cell Phone:_____

Marital Status: S M D W Separated Other_____

Applicant Social Security #:_____ Spouse Social Security #: _____

Applicant Date of Birth: _____ Spouse Date of Birth: _____

Please list dependents and other household members. (Attach separate sheet if necessary)

Name	Age	Relationship	Name	Age	Relationship
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Applicant Employer:

_____

Position: _____ Years Employed: _____

Spouse Employer: _____

Position: _____ Years Employed: _____

*if less than 3 years, please provide name of former employer_____

_____

Have you applied for Medical Assistance? _____Yes_____No if not, why?

_____

_____

Were you offered health insurance from your employer? __yes __no If you chose not to participate, why?

_____

Were you denied health insurance from your employer? __yes __ no If yes, please explain

_____

Are you eligible for COBRA benefits? __yes __no Have you filed for Bankruptcy? __yes __no

Have you applied for Medicaid? __yes __no Have you applied for County Poor Relief? __yes __no

Applications should apply for Medicaid and any other potential financial assistance programs before completing this application for Financial Assistance. If you are a resident of South Dakota, you should also apply for County Poor Relief before applying for Financial Assistance. You can apply for County Poor Relief at your local County Court House.

If you have any questions regarding financial assistance or information required on this application, please contact the Community Memorial Hospital Business Office Manager at (605) 775-2621. Please return your completed application, along with supporting documentation to the Business Office at Community Memorial Hospital.

Supporting documentation, please provide the most resent

- □ W-2 (s)
- □ Tax Return (Federal, State if applicable
- □ Pay Stub(s)
- □ Bank Statements
- □ Copies of all medical expense statements

*Community Memorial Hospital Business Office may request additional information if necessary.
By submitting this assistance application, I understand that the Community Memorial Hospital may share it and related documentation with other 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	$_____	$_____	Car Payments	$_____
Retirement / Veteran Pension	$_____	$_____	Child Care	$_____
(all sources)			Transportation Expenses	$_____
Unemployment Comp.	$_____	$_____	Medical/Dental*	$_____
Workers Comp	$_____	$_____	Insurance (car, medical, etc.)	$_____
ADC/WIC/Food Stamps	$_____	$_____	Credit Cards	$_____
Alimony/Child Support	$_____	$_____	Collection Agencies	$_____
Investment/Interest Income	$_____	$_____	Clothing	$_____
Inheritance	$_____	$_____	Utilities	$_____
Other (List_____)	$_____	$_____	Student Loans	$_____
Total Monthly Income	$_____	$_____	Tobacco Products	$_____
Net Monthly Income	$_____	$_____	Other (List_____)	$_____
Total Income last 12 months	$_____	$_____	**Total Monthly Expenses**	$_____

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

Assets (Current market value)	**Applicant**	**Spouse**	**Liabilities**	**Applicant/Spouse**
Provide Copies of Statements			Medical Bills *_____	$_____
Cash on hand/Bank/Savings	$_____	$_____	Medical Bills *_____	$_____
Investments/CD's (Market Value)	$_____	$_____	Medical Bills *_____	$_____
Loan/cash value of life insurance	$_____	$_____	Credit Card(s)	$_____
Residence: sq ft. Total _____			Loan on furniture/Appliances	$_____
Purchase Price		$_____	Home Loan	$_____
Improvements		$_____	Vehicle Loan	$_____
Estimated Value Now		$_____	Real Estate Loan	$_____
Furniture and Appliances	$_____	$_____	Student Loan	$_____
Vehicle: Year/model _____		$_____	Amount owed on Farm Equip.	$_____
Vehicle: Year/model _____		$_____	Amount owed on Livestock	$_____
Farm Real Estate: # of acres _____		$_____	Loan on Rental Property	$_____
Farm Equipment		$_____	Loan on Business	$_____
Livestock		$_____	Amount on Other	$_____
Rental Property		$_____	Amount owed to Collection	
Business		$_____	Agency	$_____
Inheritance/Settlement Pending		$_____	**Total Liabilities**	$_____
Other _____		$_____		
Total Assets		$_____		

*Out of Pocket Expense or Liability only (net of any insurance discounts, third party liability, or any other potential claim) please use a separate sheet to detail medical expenses. Copies of billing statements are acceptable.

I (We) herby acknowledge that the information giver to CMH is true and correct. I (We) authorize CMH to verify any of the information given by me. I (We) will provide documentation of this information upon request. I (We) also understand that if the information which I (We) submitted is determined to be false, it will result in denial of financial assistance and I (We) will be liable for charges for services provided.

Signed_____ Date_____

Signed_____ Date_____

INTERNAL USE ONLY

Full_____ Partial_____

Approved_____ Date_____ Denied_____ Date_____

Approved by_____ Denied by_____