Regional Health

Financial Assistance Application

Refer to the Financial Assistance Checklist on the reverse side for further assistance.

LAST NAME OF RESPONSIBLE PERSON (print)	FIRST NAME		
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER		AGE
STREET ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER ❑ Full Time ❑ Part Time	WORK PHONE NUMBER	MONTHLY GROSS INCOME	

LAST NAME OF SPOUSE / SIGNIFICANT OTHER (print)	FIRST NAME		
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER		AGE
EMPLOYER ❑ Full Time ❑ Part Time	WORK PHONE NUMBER	MONTHLY GROSS INCOME	

RESPONSIBLE PERSON'S OTHER INCOME	SPOUSE/SIGNIFICANT OTHER INCOME	ANNUAL GROSS HOUSEHOLD INCOME
$	$	$
NUMBER OF CHILDREN IN FAMILY	TOTAL NUMBER IN FAMILY	AGES OF DEPENDENT CHILDREN

Have you applied for Medicaid? .....❑ Yes ❑ No

If no, please indicate why:_____

Have you applied for County Assistance? .....❑ Yes ❑ No

If no, please indicate why:_____

Who is Eligible for South Dakota Medicaid?
You must meet the eligibility standards for the below programs.
You may qualify if you are:
___a low income adult with dependent children
___a pregnant woman
___receiving supplemental security income

Have you applied for the Health Insurance Exchange Options? .....❑ Yes ❑ No

If no, please indicate why: .....
- ○ Employer offers health insurance coverage and I am covered by the plan.
- ○ Employer offers health insurance coverage but I did not sign up.
- ○ Employer does not offer health insurance coverage (letter from Employer required).

Documented Proof of All Income Is Required & Must Accompany Your Application

❑ Federal Tax Return *(most recent)*—If claimed as dependent by someone else, must provide claimants most recent tax return.

❑ 3 Months Current Pay Stubs—must include Responsible Person and Spouse / Significant Other

Other Income Source—attach supporting documents

❑ Alimony	❑ Food Stamps/Housing	❑ Railroad Retirement	❑ VA Assistance
❑ Child Support	❑ Life Insurance	❑ Social Security Insurance	❑ Worker's Compensation
❑ Disability	❑ Pension	❑ Unemployment	❑ Other—list: _____

Assets

Cash on Hand - checking ..... $_____
Cash on Hand - savings ..... $_____
Stocks, Bonds, and/or Retirement Funds..... $_____
Vehicle: _____ Year:_____ ..... $_____
Vehicle: _____ Year:_____ ..... $_____
Home - estimated market value..... $_____
Other Assets: ..... $_____
Other Assets: ..... $_____
Total Assets ..... $ 0.00

Expenses

Housing Payment/Rent .....$ _____ ❑ Rent ❑ Own
Vehicle Loan.....$ _____
Vehicle Loan.....$ _____
Child Care .....$ _____
Child Support.....$ _____
Other Loan: .....$ _____
Other Loan: .....$ _____
Other:.....$ _____
Total Monthly Expenses .....$ 0.00

I acknowledge the information given to Regional Health is true and correct to the best of my knowledge. I authorize Regional Health to verify any or all the information given and to obtain a consumer credit report to be obtained as necessary.

Responsible Person Signature: _____ **Print to Sign & Date** _____ Date: _____

Spouse/Significant Other Signature:_____ Date: _____

Regional Health

Financial Assistance Checklist

Initial if **YES**	***INFORMATION REQUIRED for complete application*** **Do Not Send Original Documents -Please Send Only Copies of Your Supporting Documents**
	1. The demographic information is completed for the responsible person and spouse/significant other. *(i.e., address, telephone number, etc.)*
	2. The dependent information is completed. *(i.e., number in household, names, ages, etc.)*
	3. The employment and income information is completed for the responsible person and spouse / significant other.
	4. A copy of most recent years IRS Tax Return is attached.
	5. A copy of 3 most recent months' pay stubs (or employment benefit) is attached for the responsible person and spouse / significant other.
	6. If you are self-employed, schedules C, E, F, and IRS Form 8965 (Health Insurance Coverage Exemption) are required.
	7. If applicable, a copy of current year social security benefits for you and/or your spouse / significant other are attached.
	8. If applicable, a copy of workers compensation benefit you receive is attached.
	9. If applicable, a copy of food stamp letter is attached.
	10. If you have limited income and another party is helping you meet your daily needs, the letter of financial support at the bottom of this form has been completed.
	11. If you meet the eligibility standards for South Dakota Medicaid but do not meet the income requirements, a letter of denial is attached. (See Financial Assistance Application – Who is Eligible for South Dakota Medicaid).
	12. If you were denied for County Assistance, a letter of denial is attached.
	13. If your employer does not offer a health insurance plan option, a letter from your employer is attached.
	14. Has the responsible person and spouse/significant other signed and dated the form?
	15. Application and All Supporting Documents may be returned to any Regional Health patient registration area or mailed to PO Box 6000, Rapid City, SD 57709. If you have any questions, please call our Patient Financial Services department at (605)755-7660 for further assistance.

LETTER OF FINANCIAL SUPPORT

I, _____ certify that I am providing the applicant with the following support each month: (List specific support: food, heat, telephone, shelter, etc.): _____

_____

and the total cost of this support is $ _____. I do not ask or expect to be reimbursed for the cost of this support. I provide this support because: (List reason: short term medical situation, short term unemployment, recent relocations, etc.)

_____

I have been providing this support for _____ months. I understand that my signature does not make me liable for his/her debts. I certify that this information I provided is true. Therefore, I authorize by my signature for Regional Health to contact me if necessary at the below listed phone number to verify any information I have provided.

Supporter's Signature:_____ **Print to Sign & Date** _____Date: _____Time: _____

Name (PRINTED):_____

Street Address: _____City: _____

State:_____ Zip Code: _____Phone Number:_____