

PRIMARY APPLICANT			
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

SPOUSE / SIGNIFICANT OTHER / HOUSEHOLD MEMBER			
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

DEPENDENT CHILDREN LIVING IN HOUSEHOLD			
LAST NAME / FIRST NAME (print)	DATE OF BIRTH	LAST NAME / FIRST NAME (print)	DATE OF BIRTH
LAST NAME / FIRST NAME (print)	DATE OF BIRTH	LAST NAME / FIRST NAME (print)	DATE OF BIRTH

*Additional information, including additional employment, dependents, assets, or liabilities may be submitted on a separate paper along with this form.*

INSURANCE INTERVIEW PRIMARY APPLICANT		*a letter from employer may be required
<i>Please review and complete all questions. Check all boxes that apply</i>		
<input type="checkbox"/> My employer offers health insurance and I am covered by the plan. <input type="checkbox"/> The employer of my Spouse / Significant Other offers health insurance and I am covered by the plan.		
<b>My employer or Spouse / Significant Other's employer</b>		
<input type="radio"/> *does NOT offer health insurance coverage. <input type="radio"/> *offers health insurance coverage and I am not eligible. (Please indicate why: _____ ) <input type="radio"/> offers health insurance coverage but I did not sign up. (Please indicate why: _____ )		
Are you currently eligible for COBRA benefits? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Have you applied for the Health Insurance Marketplace options? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Are you eligible for Veterans Administration health benefits? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Are you eligible for health care through Indian Health Services? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Have you applied for State Medicaid? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Who is Eligible for SD Medicaid?</b> You must meet program eligibility. You may qualify if you are: <ul style="list-style-type: none"> <li>• a low income adult with dependent children</li> <li>• a pregnant woman</li> </ul>	

INSURANCE INTERVIEW SPOUSE / SIGNIFICANT OTHER		*a letter from employer may be required
<i>Please review and complete all questions. Check all boxes that apply</i>		
<input type="checkbox"/> My employer offers health insurance and I am covered by the plan. <input type="checkbox"/> The employer of my Spouse / Significant Other offers health insurance and I am covered by the plan.		
<b>My employer or Spouse / Significant Other's employer</b>		
<input type="radio"/> *does NOT offer health insurance coverage. <input type="radio"/> *offers health insurance coverage and I am not eligible. (Please indicate why: _____ ) <input type="radio"/> offers health insurance coverage but I did not sign up. (Please indicate why: _____ )		
Are you currently eligible for COBRA benefits? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Have you applied for the Health Insurance Marketplace options? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Are you eligible for Veterans Administration health benefits? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Are you eligible for health care through Indian Health Services? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Have you applied for State Medicaid? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Who is Eligible for SD Medicaid?</b> You must meet program eligibility. You may qualify if you are: <ul style="list-style-type: none"> <li>• a low income adult with dependent children</li> <li>• a pregnant woman</li> </ul>	

APPLICANT(S) ACKNOWLEDGEMENT	
I/We acknowledge the information given to Monument Health is true and correct to the best of my knowledge. I/We affirm I/We have not omitted any information that may be needed to complete the financial assistance application review. I/We authorize Monument Health to contact me at the above phone numbers. I/We authorize Monument Health to verify any or all of the information given and to obtain a consumer credit report to be obtained as necessary.	
Primary Applicant Signature: _____	Date: _____ Time: _____
Spouse / Significant Other Signature: _____	Date: _____ Time: _____

Documented proof of all income is required and must accompany your application:

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

\*Gross = before taxes or deductions

- I am a Claimed Dependent of Another Party (Must Provide Claimants Most Recent Federal Tax Return)  
 I am Self Employed     Responsible Party     Spouse Significant Other (Must Provide Most Recent Federal Tax Return – Business and Personal)

OTHER HOUSEHOLD INCOME SOURCES		Must Provide Copies of All Supporting Documents	
SOURCE:	MONTHLY \$	SOURCE:	MONTHLY \$
Unemployment	\$	Railroad Retirement	\$
Workers Compensation	\$	Pension or Retirement	\$
Social Security or Social Security Disability Income	\$	Dividends and Interest	\$
Veterans Benefits	\$	Investments / IRA Distribution	\$
Alimony	\$	Estates and Trusts	\$
Child Support	\$	Insurance and Annuity Payments	\$
TANF / SNAP / WIC (government programs)	\$	Legal and/or Charitable Awards, Settlements, Judgments	\$
Public Housing Allowance	\$	Student Loans, Grants, Stipends	\$
Utilities Assistance / Energy Assistance	\$	Rent and Royalties	\$
<b>MONTHLY TOTAL:</b>	<b>\$</b>	<b>MONTHLY TOTAL:</b>	<b>\$</b>

ASSET INFORMATION	
Cash on Hand / In Bank / In Savings	\$
CDs / Investments / Stocks and Bonds (market value)	\$
Retirement Fund Accounts	\$
Life Insurance Cash or Loan Value	\$
Home – Estimated Market Value	\$
Primary Vehicle – Year: Model:	\$
Other Vehicle – Year: Model:	\$
Other Vehicle – Year: Model:	\$
Rental Property – Address:	\$
Business Property – Address:	\$
Other Real Estate / Land - # of acres:	\$
Other Assets – type:	\$
Other Assets – type:	\$
Other Assets – type:	\$
<b>TOTAL ASSETS VALUE:</b>	<b>\$</b>

LIABILITY INFORMATION	
Housing Payment / Rent	<input type="checkbox"/> Rent <input type="checkbox"/> Own    \$
Vehicle Loan – Model:	\$
Vehicle Loan – Model:	\$
Other Loan – Description:	\$
Other Loan – Description:	\$
Other Loan – Description:	\$
Child Support	\$
Child Care	\$
Credit Card	\$
Credit Card	\$
Other:	\$
Other:	\$
Other:	\$
Other:	\$
<b>TOTAL LIABILITIES:</b>	<b>\$</b>

**REQUEST FOR FINANCIAL ASSISTANCE CHECKLIST**

The personal information is complete for all applicants **AND**  The dependent information is completed.  
 The insurance interview is fully complete for all applicants.  
 Where indicated by an \*, a 'Letter of Explanation' on company letterhead has been included **AND** includes a clear name and phone number to verify.  
 The employment information is fully complete for all applicants **AND**  3 months of current and consecutive paystubs are included.  
 If self-employed, the most recent federal tax returns are provided, including Schedules C, E, and F.  
 If a claimed dependent of another person, a copy of the claimant's most recent federal tax return is provided.  
 Proof of each and all other household income sources have been included.  
 If support is being provided by another party, the 'Letter Acknowledgement of Financial Support' is fully complete.

**LETTER / ACKNOWLEDGEMENT OF APPLICANT(S) FINANCIAL SUPPORT**

I, (print full name) \_\_\_\_\_ certify that I am providing the applicant(s) with the following support each month:  Housing/Shelter     Food     Financial Stipend in the Amount of \$ \_\_\_\_\_ each month. I provide this support because the applicant(s) have experienced a  Short Term Medical Situation     Short Term Unemployment     Recent Relocation. 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 for Monument Health to contact me at the below listed phone number to verify any information I have provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Return to any Monument Health patient registration area or USPS mail all documents to PO Box 6000, Rapid City, SD 57709.