

Financial Assistance Application

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.		
My employer or Spouse / Significant Other's employer		
<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		Who is Eligible for SD Medicaid? You must meet program eligibility. You may qualify if you are: <ul style="list-style-type: none"> • a low income adult with dependent children • a pregnant woman

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.		
My employer or Spouse / Significant Other's employer		
<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		Who is Eligible for SD Medicaid? You must meet program eligibility. You may qualify if you are: <ul style="list-style-type: none"> • a low income adult with dependent children • a pregnant woman

APPLICANT(S) ACKNOWLEDGEMENT	
<p>I/We acknowledge the information given to SDSC 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 SDSC to contact me at the above phone numbers. I/We authorize SDSC to verify any or all of the information given and to obtain a consumer credit report to be obtained as necessary.</p>	
Primary Applicant Signature: _____	Date: _____ Time: _____
Spouse / Significant Other Signature: _____	Date: _____ Time: _____



Financial Assistance Application

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	\$
MONTHLY TOTAL:	\$	MONTHLY TOTAL:	\$

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:	\$
TOTAL ASSETS VALUE:	\$

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:	\$
TOTAL LIABILITIES:	\$

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 SDSC 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 SDSC patient registration area or USPS mail all documents to PO Box 6000, Rapid City, SD 57709.