

Hegg Memorial Health Center
Financial Assistance Application & Patient Financial Information

This form is to provide information to assist you in satisfying your financial obligation to Hegg Memorial Health Center.

Applicant Name _____ Spouse or Significant Other Name _____

Current Address _____ Renting _____ Buying _____ Years lived at _____

City _____ State _____ Zip _____ Home Telephone _____

Marital Status: S M D W Sep Other

Applicant Social Security # _____ Spouse Social Security # _____

Applicant Birth Date _____ Spouse Birth Date _____

Please list dependents: (attach separate sheet if necessary)

Table with 6 columns: Name, Age, Relationship, Name, Age, Relationship. Includes three rows of blank lines for data entry.

Applicant Employer _____ Spouse or Sig. Other Employer _____

Position _____ Years Employed _____ 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 _____

Applicants 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 must also apply for County Poor Relief before applying for Financial Assistance. If you have any questions regarding financial assistance or information required on this application, please contact the Patient Accounts Manager or Financial Counselor at Hegg Memorial Health Center, 712-476-8000. Please return your completed application, along with supporting documentation, to the Business Office where you received your service.

Patient Financial Services may request additional information if necessary.

By submitting this assistance application, I understand that the Patient Accounting department at Hegg Memorial Health Center receiving this application may share it and related documentation with other Patient Accounting departments at Hegg Memorial Health Center that are involved with my treatment or may have provided separate treatment.

This institution is an equal opportunity provider and employer.

	Applicant	Spouse/Other Household Members	Monthly Household Expenses	Applicant/Spouse/Other Household Members
Monthly Household Income				
Employment (Gross/Net Pay)	\$ _____	\$ _____	Rent/Mortgage	\$ _____
Social Security/Disability	\$ _____	\$ _____	Food	\$ _____
Retirement/Veteran Pension (all sources)	\$ _____	\$ _____	Car Payments	\$ _____
Unemployment Comp.	\$ _____	\$ _____	Child Care	\$ _____
ADC/WIC/Food Stamps	\$ _____	\$ _____	Transportation/car expense	\$ _____
Alimony/Child Support	\$ _____	\$ _____	Medical/Dental*	\$ _____
Investment/Interest Income	\$ _____	\$ _____	Insurance (car, medical, etc.)	\$ _____
Other (List _____)	\$ _____	\$ _____	Credit Card (_____)	\$ _____
Total Monthly Income	\$ _____	\$ _____	Collection Agencies	\$ _____
Net Monthly Income	\$ _____	\$ _____	Clothing	\$ _____
Total Income last 12 months	\$ _____	\$ _____	Other (List _____)	\$ _____
Copy of Tax Return and last 2 months pay stubs are required.			Total Monthly Expenses	\$ _____

ASSETS (Current market value)

Cash on hand/Bank/Savings	\$ _____
Investments/CD's (Market value)	\$ _____
Loan/Cash value of Life Insurance	\$ _____
Residence: sq. ft. total _____	
Purchase Price	\$ _____
Estimated Value Now	\$ _____
Primary Vehicle: Year/Model _____	\$ _____
Other Vehicles: Year/Model _____	\$ _____
Other Vehicles: Year/Model _____	\$ _____
Farm Real Estate: # of acres _____	\$ _____
Farm Equipment	\$ _____
Livestock	\$ _____
Rental Property	\$ _____
Business	\$ _____
Other _____	\$ _____
Total Assets	\$ _____

LIABILITIES

Medical Bill* _____	\$ _____
Medical Bill * _____	\$ _____
Medical Bill * _____	\$ _____
Credit Card(s)	\$ _____
Home Loan (current balance)	\$ _____
Loan on furniture & appliances	\$ _____
Primary Vehicle Loan (current balance)	\$ _____
Non-Primary Vehicle Loan (current balance)	\$ _____
Real Estate Loan (current balance)	\$ _____
Amount owed on farm equip.	\$ _____
Amount owed on livestock	\$ _____
Loan on Rental Property	\$ _____
Loan on Business	\$ _____
Amount owed on other	\$ _____
Amt owed to Collection Agency	\$ _____
Total Liabilities	\$ _____

* Out-of Pocket Expense or Liability only (net of any insurance, discounts, third party liability, or any other potential claim).

Were you offered health insurance from your employer? ___Yes ___No
 Were you denied health insurance by your employer? ___Yes ___No
 Have you applied for insurance via the insurance exchange? ___Yes ___No

Are you eligible for COBRA benefits? ___Yes ___No

I hereby acknowledge that the information given to Hegg Memorial Health Center is true and correct. I authorize Hegg Memorial Health Center to verify any of the information given by me. I will provide documentation of this information upon request.

Signed _____ Date _____

Signed _____ Date _____

INTERNAL USE ONLY

Date Sent: _____ Returned Date: _____

Approved _____ Date _____ Denied _____ Date _____

Approved by: _____ Denied By: _____

ATTACHMENT II - Iowa

PUBLIC ASSISTANCE BENEFITS

You may be eligible for MEDICAID or for other state or federal benefits that would pay for all **or** part of your medical bill.

We have enlisted Sioux County Department of Human Services Group to help explore what benefits may be available to you. The Sioux County Department of Human Services is a public interest firm that provides free services to those who qualify. A representative from the Sioux County Department of Human Services can help you to determine whether it is appropriate for them to assist you in making an application for benefits.

If the Sioux County Department of Human Services accepts your case, they will follow your case until your application has been approved or denied. All of this will be done at no charge to you.

If you have any questions regarding this information, contact:

Sioux County Department of Human Services
215 Central Ave SE
PO Box 375
Orange City, IA 51041
(712) 737-2943 or 1-800-337-2943

Hegg Memorial Health Center contact person:

Financial Counselor
712-476-8000

ATTACHMENT II – South Dakota

PUBLIC ASSISTANCE BENEFITS

You may be eligible for MEDICAID or for other state or federal benefits that would pay for all **or** part of your medical bill.

We have enlisted The Midland Group to help explore what benefits may be available to you. The Midland Group is a public interest law firm that provides free legal services to those who qualify. A representative from The Midland Group will contact you to determine whether it is appropriate for them to assist you in making an application for benefits.

If The Midland Group accepts your case, they will follow your case until your application has been approved or denied. All of this will be done at no charge to you.

If you have any questions regarding this information, contact:

The Midland Group
625 S. Minnesota Ave, Suite 101
Sioux Falls, SD 57104
(605) 339-3310 or 1-800-595-7868

Hegg Memorial Health Center contact person:

Financial Counselor
712-476-8000

ATTACHMENT III

Hegg Memorial Health Center

CONSENT TO RELEASE OF INFORMATION TO COUNTY OF RESIDENCE

I, the undersigned, understand that I will receive or have received the above healthcare facility and at the time of treatment, I either have/had no insurance coverage, and/or am not aware of any insurance coverage, commercial or otherwise, to which the healthcare organization may submit claims on my behalf for the purpose of obtaining payment and/or related benefits for my healthcare treatment. I also affirm that I am not eligible for Indian Health Service benefits nor am I a member of a Native American tribe and thus Indian Health Services and/or the Bureau of Indian Affairs are not potential resources for the hospital to submit claims for my healthcare treatment on my behalf. I also affirm that I have not served in any branch of the military for any period of time, or if I have served in a branch of the military, the healthcare that I am receiving is not eligible or covered by the Veteran's Administration.

I understand that I may or may not have the personal financial resources to pay the costs for healthcare treatment and care as recommended by my attending/treating physician and as such, this form is being signed by me to authorize all persons, agencies, or institutions (including this healthcare organization and my physician(s)) to release to the welfare director, auditor, states attorney, and/or county commissioners of my county of residence, information concerning my social security number, medical information concerning my healthcare treatment, and financial information concerning me and/or members of my household. This information will be required by my county of residence to process benefits on my behalf for which I may be eligible.

By signing, I indicate that I fully understand this Consent to Release of Information, and am voluntarily signing below.

Dated this _____ day of _____, year.

*Patient Social Security Number

*County of Residence

*Patient

Patient Representative

*Witness

Witness

*Account #

*Required

ATTACHMENT IV

**Hegg Memorial Health Center Health
Financial Assistance Application
Presumptive Eligibility**

Patient Name: _____ Patient SSN: _____

Patient Date of Birth: _____ Patient Account Number: _____

Eligibility Criteria that may be considered:

Initial if Yes	Reason for Eligibility
	Homeless or received care from a homeless clinic
	No income
	Participation in Women's, Infant's and Children's programs (WIC)
	Food stamp eligibility
	Subsidized school lunch program eligibility
	Eligibility for other state or local assistance programs that are un-funded (e.g Medicaid spend-down)
	Family or friends of the patient have provided information establishing the household's inability to pay
	Low income/subsidized housing is provided as a valid address
	Patient is deceased with no known estate
	Patient/Grantor is incarcerated, has no assets and is not eligible for parole within the next 18 months.
	Other (Describe):

Verification

Attach documentation or written attestations demonstrating eligibility

Submitters Signature: _____ Date: _____

Print Submitters Name: _____ Title: _____