ATTACHMENT I **CONFIDENTIAL**

Hegg Health Center
Financial Assistance Application & Patient Financial Information

This form is to provide information to assist you in satisfying your financial obligation to Hegg 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)

Name	Age	Relationship	Name	Age	Relationship

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 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 Health Center receiving this application may share it and related documentation with other Patient Accounting departments at Hegg Health Center that are involved with my treatment or may have provided separate treatment.

This institution is an equal opportunity provider and employer.

Monthly Household Income	Applicant	Spouse/Other Household Members	Monthly Household Expenses	Applicant/Spouse/ Other Household Members
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)			**LIABILITIES**	
Cash on hand/Bank/Savings		$_____________	Medical Bill* ____________	$_______________
Investments/CD's (Market value)		$_____________	Medical Bill *____________	$_______________
Loan/Cash value of Life Insurance		$_____________	Medical Bill *____________	$_______________
Residence: sq. ft. total ____________			Credit Card(s)	$_______________
Purchase Price	$_____________		Home Loan (current balance)	$_______________
Estimated Value Now		$_____________	Loan on furniture & appliances	$_______________
Primary Vehicle: Year/Model ___________________		$_____________	Primary Vehicle Loan (current balance)	$_______________
Other Vehicles: Year/Model ___________________		$_____________	Non-Primary Vehicle Loan (current balance)	$_______________
Other Vehicles: Year/Model ___________________		$_____________	Real Estate Loan (current balance)	$_______________
Farm Real Estate: # of acres _____________		$_____________	Amount owed on farm equip.	$_______________
Farm Equipment		$_____________	Amount owed on livestock	$_______________
Livestock		$_____________	Loan on Rental Property	$_______________
Rental Property		$_____________	Loan on Business	$_______________
Business		$_____________	Amount owed on other	$_______________
Other ____________________		$_____________	Amt owed to Collection Agency	$_______________
	Total Assets	$_____________	**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 Health Center is true and correct. I authorize Hegg 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 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 Health Center contact person:

Financial Counselor
712-476-8000

ATTACHMENT III

Hegg 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 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: ________________