DUNES
SURGICAL HOSPITAL
In association with Mercy Medical Center

Dear Patient,

Personal or family situations sometimes make it difficult or impossible for a person to pay for health care services. We are committed to being a community resource for patient care. While health care is expensive, not everyone can pay for his or her care at the same level. This should not be a reason for them not to receive care.

Attached please find our Financial Assistance Application. **This application must be completed in full and returned with all supporting documentation as soon as possible to be considered for our financial assistance program.** We **must** have proof of income or lack thereof in order to consider your application for Financial Assistance.

Return:

- Completed Financial Assistance application
- Copy of most recent Federal Income Tax Return (If you file)
- Copies of you and/or your spouses' three most recent pay stubs
- Documentation of you and/or your spouses' unemployment benefits, pension, disability, and/or social security.
- Notice from your state Medicaid program that you have applied for coverage and have been determined ineligible.
- Copy of any other information that you believe is pertinent to your income or situation. For example, support for all current oustanding medical bills (after payment by all third parties) for potential determination of assistance based on medical indigency.

If approved for assistance, Dunes Surgical Hospital accounts will be adjusted in accordance with the Dunes Surgical Hospital Financial Assistance Policy & guidelines.

If you have any questions or want to make payment arrangements please call 605-217-4800 and our Billing Office will be happy to help you. Our business hours are 8:00 am to 4:30 pm, Monday through Friday.

Keep this cover letter for your records

Thank you,

Dunes Surgical Hospital

Dunes Surgical Hospital
Financial Assistance Application

We are required by law to keep information about you confidential. This information will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels**.**

Required Documents: *****Incomplete Applications will not be processed*****

- Most recent Federal Income Tax Return, if you file (Including Schedule C, if Self Employed)
- Three recent pay stubs for Applicant and working Spouse/Partner
- Proof of Social Security, Pension, Unemployment, or Disability payments – If received
- Notice from your state Medicaid program that you have applied for coverage and have been determined ineligible
- Optional - support for all current outstanding medical bills (after payment by all third parties).
- If no income: A letter, written and signed, by person or persons paying your living expenses

Applicant Name:_____ Date of Birth:_____ Social Security#:_____

Spouse/Partner Name:_____ Date of Birth:_____ Social Security#:_____

Address:_____ City:_____ State:_____ Zip:_____

Contact Phone#:_____

DEPENDENTS **UNDER 18**:

Name:_____ Date of Birth:_____ Age:_____ Relationship to Applicant:_____

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Name:_____ Date of Birth:_____ Age:_____ Relationship to Applicant:_____

Name:_____ Date of Birth:_____ Age:_____ Relationship to Applicant:_____

Applicant Employer Name:_____ Gross Monthly income:_____

Spouse Employer Name:_____ Gross Monthly income:_____

Other Monthly Income	Applicant	Spouse	Other
Social Security/Social Security Disability			
Pension/IRA/403(b), Annuity Cash Out			
Child Support and/or Alimony			
Federal Assistance (Cash, Food Stamps, Etc.)			
Worker's Comp/Unemployment			
Stocks, Bonds, Annuities or Rental Property			
Other			
Total Gross Monthly Income			

Other Annual Income (If Self Employed)	Applicant	Spouse	Other
Adjusted Gross Income			
Total Annual Income (If applicable)			
Total Countable Assets (First $5000 is protected)			

Assets:	Value
Cash on Hand	
Checking Account Balance	
Savings Account Balances	

Assets:	Value
Investments or Other Securities	
Retirement Savings	
Life Insurance Policy Cash Value	

Property:

Primary Home/Property Value	
Balance owed on Mortgage	
Monthly Payment	

Other Property Value	
Balance owed on Mortgage	
Monthly Payment	

Vehicles owned (cars, trucks, RVs, ect)

Year _____
Make & Model _____
Mileage _____
Balance owed _____

Year _____
Make & Model _____
Mileage _____
Balance owed _____

Circle all State/Federal Programs applied for in the past year:

Medicaid/Title 19 Social Security/ Disability Medication Assistance Other: _____

Did you or your spouse become unemployed in the past 90 days? **Yes or No** Was insurance available? **Yes or No**
Was insurance received? **Yes or No** Are you eligible for Cobra? **Yes or No** If yes, company name: _____

Please provide or attach any additional information you feel would be helpful in understanding your current situation. (If unemployed, please note how you are meeting your monthly expenses)

CLIENT AFFIRMATION: I affirm that the statements made herein are a true and correct listing of my assets. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance.

Patient Signature:_____ Date:_____

Return completed application form and required documentation to: Dunes Surgical Hospital
Attention: Financial Assistance
600 Sioux Point Road
Dakota Dunes, SD 57049