

**Platte Health Center / Avera  
Patient Assistant Application &  
Financial Information**

This form is to provide information to assist you in satisfying your financial obligation to Platte Health Center / Avera Health.

Applicant Name \_\_\_\_\_

Spouse 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 # \_\_\_\_\_

\_\_\_ Over 65 \_\_\_ Blind \_\_\_ Permanently Disabled

\_\_\_ Over 65 \_\_\_ Blind \_\_\_ Permanently Disabled

\_\_\_\_\_ Date of Disability Determination

\_\_\_\_\_ Date of Disability Determination

Applicant Birth Date \_\_\_\_\_

Spouse Birth Date \_\_\_\_\_

Former Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(If under 3 years at current)

Dependent children under 18 years old living in your household: (attach separate sheet if necessary)

**Name                      Age    Relationship**

**Name                      Age    Relationship**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Applicant Employer \_\_\_\_\_

Spouse Employer \_\_\_\_\_

Position \_\_\_\_\_ Years Employed \_\_\_\_\_

Position \_\_\_\_\_ Years Employed \_\_\_\_\_

If employed less than 3 years at current employer, please complete the following:

Applicant Former Employer \_\_\_\_\_

Spouse Former Employer \_\_\_\_\_

**Insurance Information:**

Health Insurance Provider \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Subscriber # \_\_\_\_\_

Policy Owner \_\_\_\_\_

Medicare # \_\_\_\_\_

Medicaid # \_\_\_\_\_

Applicants should first apply for Medicaid 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 either program or information required on this application, please contact the Patient Accounts Manager at Platte Health Center / Avera, (605) 337-3364.

<b>Monthly Household Income</b>	<b>Applicant</b>	<b>Spouse</b>	<b>Monthly Household Expenses</b>	<b>Applicant/Spouse</b>
Employment (Gross/Net Pay)	\$ _____	\$ _____	Rent/Mortgage	\$ _____
Part-Time Jobs (Gross/Net)	\$ _____	\$ _____	Food	\$ _____
Social Security/Disability	\$ _____	\$ _____	Utilities	\$ _____
Veteran Pension	\$ _____	\$ _____	Car Payments	\$ _____
Retirement (all sources)	\$ _____	\$ _____	Child Care	\$ _____
Unemployment Comp.	\$ _____	\$ _____	Transportation/car expense	\$ _____
Workers Comp.	\$ _____	\$ _____	Medical/Dental	\$ _____
Union Benefits	\$ _____	\$ _____	Insurance (car, medical, etc..)	\$ _____
Inheritance	\$ _____	\$ _____	Credit Card (_____)	\$ _____
ADC/WIC/Food Stamps	\$ _____	\$ _____	Credit Card (_____)	\$ _____
Alimony/Child Support	\$ _____	\$ _____	Collection Agencies	\$ _____
Savings Interest Income	\$ _____	\$ _____	Clothing	\$ _____
Investment Income	\$ _____	\$ _____	Other (List_____)	\$ _____
Other (List_____)	\$ _____	\$ _____	Other (List_____)	\$ _____
				\$ _____
<b>Total Monthly Income</b>	\$ _____	\$ _____	<b>Total Monthly Expenses</b>	\$ _____
<b>Net Monthly Income</b>	\$ _____	\$ _____		
<b>Total Income last 12 months</b>	\$ _____	\$ _____		
<b>Total Income last 3 months</b>	\$ _____	\$ _____		

Please provide proof of income. Acceptable proof includes tax returns and/or paycheck stubs.

**ASSETS (Current market value)**

Cash on hand/Bank/Savings	\$ _____
Investments/CD's (Market value)	\$ _____
Loans to Others	\$ _____
Loan/Cash value of Life Insurance	\$ _____
Furniture & Appliances	\$ _____
Residence: sq. ft. total _____	
Purchase Price	\$ _____
Improvements	\$ _____
Estimated Value Now	\$ _____
Vehicle: Year/Model _____	\$ _____
Vehicle: Year/Model _____	\$ _____
Farm Real Estate: # of acres _____	\$ _____
Farm Equipment	\$ _____
Livestock	\$ _____
Rental Property	\$ _____
Business	\$ _____
Inheritance/settlement pending	\$ _____
Other _____	\$ _____
<b>Total Assets</b>	\$ _____

**LIABILITIES**

Medical Bill _____	\$ _____
Medical Bill _____	\$ _____
Medical Bill _____	\$ _____
Credit Card(s)	\$ _____
Loan on furniture & Appliances	\$ _____
Home Loan	\$ _____
Vehicle Loan	\$ _____
Vehicle Loan	\$ _____
Real Estate Loan	\$ _____
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	\$ _____
<b>Total Liabilities</b>	\$ _____

Bank Name \_\_\_\_\_ Checking Account # \_\_\_\_\_ Balance \$ \_\_\_\_\_  
Address \_\_\_\_\_ Savings Account # \_\_\_\_\_ Balance \$ \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Bank Name \_\_\_\_\_ Checking Account # \_\_\_\_\_ Balance \$ \_\_\_\_\_  
Address \_\_\_\_\_ Savings Account # \_\_\_\_\_ Balance \$ \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Name of Contract/Mortgage Holder \_\_\_\_\_

Name of Landlord \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Were you offered health insurance from your employer? \_\_\_ Yes \_\_\_ No

Were you denied health insurance by your employer? \_\_\_ Yes \_\_\_ No

Are you eligible for COBRA benefits? \_\_\_ Yes \_\_\_ No

Have you applied for Medicaid or other government assistance programs? \_\_\_ Yes \_\_\_ No

Do you have a balance due at any other Avera facility? \_\_\_ Yes \_\_\_ No If Yes, amount owed. \$ \_\_\_\_\_

I hereby certify verify that the information given to PHC is true and correct. I authorize PHC to verify any of the information given by me. I will provide documentation of this information upon request. I understand that the information which I submit concerning my annual income and family size is subject to verification by PHC. I also understand that if the information which I submit is determined to be false, it will result in a denial of Patient Assistance status and that I will be liable for charges for services provided.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

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INTERNAL USE ONLY

Approved \_\_\_ Amount \_\_\_\_\_ Date \_\_\_\_\_ Denied \_\_\_ Date \_\_\_\_\_

For Admission Dated \_\_\_\_\_ to \_\_\_\_\_ Explain \_\_\_\_\_

Applicant's Share \$ \_\_\_\_\_ WK \_\_\_ MO \_\_\_\_\_

\$ \_\_\_\_\_ Lump Sum \_\_\_\_\_

Income Verified \_\_\_ Type of Verification \_\_\_\_\_

Approved by: \_\_\_\_\_ Denied By: \_\_\_\_\_