Bennett County Hospital and Nursing Home Financial Assistance Application

PRIMARY APPLICANT

LAST NAME (print)	FIRST NAME (print)	DATE OF BIRTH	
SOCIAL SECURITY NUMBER	MY CONTACT PHONE NUMBER ❑ Mobile ❑ Landline ❑ Business ❑ 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 ❑ Spouse ❑ Significant Other ❑ Household Member	
SOCIAL SECURITY NUMBER	MY CONTACT PHONE NUMBER ❑ Mobile ❑ Landline ❑ Business ❑ 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**

Please review and complete all questions. Check all boxes that apply

❑ My employer offers health insurance and I am covered by the plan.
❑ 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

❍ *does NOT offer health insurance coverage.
❍ *offers health insurance coverage and I am not eligible. (Please indicate why:_____)
❍ offers health insurance coverage but I did not sign up. (Please indicate why:_____)

Are you currently eligible for COBRA benefits? ..... ❑ Yes ❑ No
Have you applied for the Health Insurance Marketplace options? ..... ❑ Yes ❑ No
Are you eligible for Veterans Administration health benefits?..... ❑ Yes ❑ No
Are you eligible for health care through Indian Health Services? ..... ❑ Yes ❑ No
Have you applied for State Medicaid? ..... ❑ Yes ❑ No

Who is Eligible for SD Medicaid?

You must meet program eligibility.
You may qualify if you are:

- a low income adult with dependent children
- a pregnant woman

INSURANCE INTERVIEW SPOUSE / SIGNIFICANT OTHER

***a letter from employer may be required**

Please review and complete all questions. Check all boxes that apply

❑ My employer offers health insurance and I am covered by the plan.
❑ 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

❍ *does NOT offer health insurance coverage.
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- a low income adult with dependent children
- a pregnant woman

APPLICANT(S) ACKNOWLEDGEMENT

I/We acknowledge the information given to Bennett County Hospital and Nursing Home 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 BCHNH to contact me at the above phone numbers. I/We authorize BCHNH to verify any or all of the information given and to obtain a consumer credit report to be obtained as necessary.

Primary Applicant Signature: _____ **Print to Sign & Date** _____ Date:_____ Time: _____

Spouse / Significant Other Signature:_____ Date:_____ Time: _____

Bennett County Hospital and Nursing Home 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		LIABILITY INFORMATION	
Cash on Hand / In Bank / In Savings	$	Housing Payment / Rent ❑ Rent ❑ Own	$
CDs / Investments / Stocks and Bonds (market value)	$	Vehicle Loan – Model:	$
Retirement Fund Accounts	$	Vehicle Loan – Model:	$
Life Insurance Cash or Loan Value	$	Other Loan – Description:	$
Home – Estimated Market Value	$	Other Loan – Description:	$
Primary Vehicle – Year: Model:	$	Other Loan – Description:	$
Other Vehicle – Year: Model:	$	Child Support	$
Other Vehicle – Year: Model:	$	Child Care	$
Rental Property – Address:	$	Credit Card	$
Business Property – Address:	$	Credit Card	$
Other Real Estate / Land - # of acres:	$	Other:	$
Other Assets – type:	$	Other:	$
Other Assets – type:	$	Other:	$
Other Assets – type:	$	Other:	$
TOTAL ASSETS VALUE:	**$**	**TOTAL LIABILITIES:**	**$**

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 Bennett County Hospital and Nursing Home to contact me at the below listed phone number to verify any information I have provided.

Signature:_____ **Print to Sign & Date** Date:____Time:_____

Street Address:_____City: _____

State:_____Zip Code:_____Phone Number:_____

Return to Bennett County Hospital and Nursing Home patient registration area or USPS mail all documents to PO Box 70, Martin, SD 57551.

FEDERAL POVERTY LEVEL 2020
ANNUAL

PERSONS IN HOUSEHOLD	100%	200%	300%	400%
1	12,760	25,520	38,280	51,040
2	17,240	34,3480	51,520	68,960
3	21,720	43,440	65,160	86,880
4	26,200	52,400	78,600	104,800
5	30,680	61,360	92,040	122,720
6	35,160	70,320	105,480	140,640
7	39,640	79,280	118,920	158,560
8	44,120	88,240	132,360	176,480
9	48,600	97,200	145,800	194,400
10	53,080	106,160	159,240	212,320