Bennett County Rural Health Clinic 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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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: _____

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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)

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.