Winner Regional Healthcare Center

745 E 8th Street
Winner, SD. 57580
Phone: (605) 842-7175
Fax: (605) 842-7173
Patient Financial Representative:
Rhonda Schroeder

FINANCIAL ASSISTANCE PROGRAM

In order to consider your application, please include copies of the last 2 year's completed Federal Tax Returns, last 3 months paystub's for all employed in household. If on SSI, please provide a copy of your Social Security Award letter. Please return as soon as possible!

Circle: Single Married Separated Divorced Widowed

Last Name_____First_____Middle_____Soc.Sec.#_____

Address_____ City_____ State_____ Zip_____

Home Ph#_____ Work Ph#_____ Cell Ph#_____

Occupation_____ Employer_____Hourly Wage_____
F/T or P/T

Spouse's Occupation_____ Employer_____Hourly Wage_____
F/T or P/T

Please indicate ALL people living in your household: (use the back if necessary)

_____

_____

Total Household Income& How Often Received

Wages/Salary (gross)_____ Self-employment_____
Income from retirement_____ Income from Social Security_____
Income from Unemployment_____ Income from Workman's Comp_____
Child Support/Alimony_____Other_____

Total Assets

Checking Account(s)_____Savings Account_____
IRA's, 401K_____ Homestead Value_____
Other Property Value_____ Automobile(s) Value_____
Other Assets_____

Total Monthly Expenses	**Monthly**	**Outstanding Balance**
Bank Loan Payment(s)	$_____	$_____
Credit Card Payment(s)	$_____	$_____

House Payment $_____$_____
Rent Payment $_____$_____
Car/Truck Payment $_____$_____
Insurance Payment(s) $_____$_____
Child Support/Daycare $_____$_____

Utilities

Phone/Cable/Internet $_____
Utilities $_____
Cell Phone $_____
Propane $_____
Gas-Automobile $_____
Groceries $_____
Paid To Other Medical Bills $_____
Prescriptions $_____
Other (Please specify) $_____

1. Have you ever declared **Bankruptcy**? ___YES ___NO If YES, when_____
2. Do you have any **judgments or liens** filed against you? If YES, please describe:_____
   _____
   _____
3. During the past 12 months, have you ever received any benefits such as welfare payments, food stamps, Medicaid, emergency assistance, County Poor Relief, Public Health Services, etc? If yes, describe_____
   _____
4. What is the approximate amount of **ALL** health bills you owe? (include hospital, clinic, and physicians):_____
   _
   _____
5. What is the amount you pay towards your medical bills each month? $_____

Applying for financial assistance is NOT to be considered a substitute for personal financial responsibility, nor will it guarantee full or partial financial assistance. Patients are expected to cooperate with the procedures for obtaining charity or other forms of financial assistance and to contribute to the cost of their care based on their individual ability to pay.

6. The total amount you owe Winner Regional Healthcare Center $_____

a. The amount you can pay Winner Regional Healthcare Center each month
$_____

7. Please include a short statement with any additional information you would like us to consider with your application with regards to your personal and financial situation.
_____
_____
_____
_____
_____

Assignment of Rights (Please Read Carefully)

By signing below I certify that the information and the statements contained in this application for financial assistance and the supporting documentation which I submit is accurate, true and correct to the best of my knowledge.

I understand that Winner Regional Healthcare Center may make reasonable requests for additional information and verification if necessary.

I understand that the information and the statements I have provided will be kept confidential by Winner Regional Healthcare Center.

I understand that I have the obligation to provide complete and truthful information to Winner Regional Healthcare Center and to cooperate with any of the request for verification and additional information.

I understand that completion of this application will allow Winner Regional Healthcare Center to consider my circumstances and makes NO representation that financial assistance is guaranteed.

Signature_____Date_____
Printed Name_____

FOR OFFICE USE ONLY	Approved	Denied
	Date	Date
	Signature	Signature