Attachment I **Confidential**

Wagner Community Memorial Hospital Avera
Wagner Community Clinic Avera

Financial Assistance Application & Patient Financial Information

This form is to provide information to assist you in satisfying your financial obligation to Wagner Community Memorial Hospital Avera and/or Wagner Community Clinic Avera..

Applicant Name _____ Spouse or Significant Other Name _____

Marital Status: S M D W Sep Other Spouse Social Security # _____ (optional)

Applicant Social Security # _____(optional) Spouse Birth Date _____

Applicant Birth Date _____ Home Telephone _____

Current Address _____ Renting _____ Buying _____ Years lived at _____

City _____State_____ Zip_____

Applicant Employer _____ Spouse or Sig. Other Employer _____

Position _____ Years Employed _____ Position _____ Years Employed _____

Please list dependents: (attach separate sheet if necessary)

Name	**Age**	**Relationship**	**Name**	**Age**	**Relationship**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Monthly Household Income	**Applicant**	**Spouse**
Employment (Gross/Net Pay)	$_____	$_____
Social Security/Disability	$_____	$_____
Retirement/Veteran Pension (all sources)	$_____	$_____
Unemployment Comp.	$_____	$_____
ADC/WIC/Food Stamps	$_____	$_____
Alimony/Child Support	$_____	$_____
Investment/Interest Income	$_____	$_____
Other (List_____)	$_____	$_____
Total Monthly Income	$_____	$_____
Net Monthly Income	$_____	$_____
Total Income last 12 months	$_____	$_____

Have you applied for Medicaid coverage? Yes _____ No _____ If not, why?_____

(optional for those <200% of FPG)

Are you currently a student? Yes _____ No _____

If you are under the age of 26 does your parent's employer offer healthcare coverage for you? Yes ____ No ____

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____

If you have any questions regarding financial assistance or information required on this application, please contact the Business Office at Wagner Com Mem Hospital Avera (WCMHA). Please return your completed application, along with supporting documentation, to the Business Office at Wagner Com Mem Hospital Avera (WCMHA).

Supporting Documentation, please provide the most recent*:

- ❑ W-2(s)
- ❑ Tax Return (Federal, State if applicable)
- ❑ Pay Stub(s)
- ❑ Bank Statement(s)

***The Business Office may request additional information if necessary**.

I hereby acknowledge that the information given to WCMH-A/WCC-A is true and correct. I authorize WCMH-A/WCC-A to verify any of the information given by me. I will provide documentation of this information upon request.

Applicant Signature: _____ Date _____

Spouse/Significant Other Signature: _____Date _____

For Internal use only:

Account Number(s):_____

Total owed to hospital $_____ Total owed to clinic $_____

Grand total $_____ Discount % _____

Approved _____ Denied _____

Collection Clerk Signature: _____ Date: _____

Or

CEO or Bus Office Manager Signature: _____ Date: _____