Avera Patient Financial Services
PO Box 8
Mitchell, SD 57301
(605)322-6470

www.avera.org

Dear Patient,

Thank you for choosing Avera for all of your health care needs. In the spirit of Charity and Justice, Avera exists in response to God's calling for a healing ministry to the sick, the elderly and the oppressed and to provide health services to all persons in need, without regard to the consideration of race, sex, creed, national origin or ability to pay.

Applicants should exhaust all other resources include State and Federal programs, before applying for financial assistance.

In order to review your eligibility for financial assistance we will need the enclosed application along with income verification returned before we can proceed.

Please return the following information to the address noted on this letter:

1. Application (Enclosed)
2. Copy of most recent income tax return (balance sheet required if agriculture/business)
3. Copies of earnings and bank statements for the last two months
4. Please provide any other related information you think could help us in determining your eligibility

By providing all documentation you may be eligible for financial assistance to cover all or a portion of your expenses.

Failure to complete or include these items will result in a returned or denied application.

If the documents are not returned within 14 business days from the date incated on this letter, **further collection activities will resume**. Upon receipt of your application and the required documents, a prompt decision will be made on your eligibliity for financial assistance. You will be notified via mail as soon as decision has been made. Please call 605-322-6470 with any questions.

Sincerely,

Avera Patient Financial Services
Attn: Financial Counselor
PO Box 8
Mitchell, SD 57301
Phone: 605-322-6470 Fax: 605-504-9230
averafinapp@avera.org

Avera Health Financial Assistance Application

Date of Service: _____ Account Number: _____ Applicant Name(s): _____

If patient is under 18, we need both parents' information and documents.

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/PARTNER			
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

HOUSEHOLD 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)	CITY	WORK PHONE	MONTHLY *GROSS INCOME

*Gross = before taxes or deductions

Dependents (If more than 4 dependents use separate page)

Full Name	**Relationship**	**Birth Date** *(mm-dd-yyyy)*
1.		
2.		
3.		
4.		

Homeless or received care from a homeless clinic? ..... ❑ Yes ❑ No
Food Stamps/WIC Eligible? ..... ❑ Yes ❑ No
Is Patient/Guarantor Incarcerated? ..... ❑ Yes ❑ No
Low income/subsidized housing eligible? ..... ❑ Yes ❑ No
Patient/Guarantor is deceased with no estate? ..... ❑ Yes ❑ No

Subsidized school lunch program eligible? ..... ❑ Yes ❑ No
Eligible for other state or local assistance programs? ..... ❑ Yes ❑ No
If you have no reported income, how are you being supported? Explain Below:
_____
_____

FOR INCOME/ASSETS LISTED, YOU MUST PROVIDE THE FOLLOWING FOR EACH MEMBER OF THE HOUSEHOLD:

- ❑ Employment – 2 Months Pay Stubs
- ❑ Unemployment – Benefit Letter
- ❑ Social Security/Pension – Benefit Letter
- ❑ Tax Return – Form 1040 and ALL Schedules
- ❑ Child Support – Verification of Payments Received (Last 12 Months)
- ❑ Bank Statements – ALL Checking/Savings Accounts (Last 2 Months)
- ❑ Last Pay Stub from Any Other Jobs in the Current Year
- ❑ Other:

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

Primary Applicant (Print): _____ Signature: _____ Date: _____

Spouse/Partner (Print): _____ Signature: _____ Date: _____

Please return this application and supporting documentation within 14 days of receipt:
Mail to Avera Health P.O. Box 8 Mitchell, SD 57301 - Fax to 605-504-9230 - Email to AveraFinApp@Avera.org