# Financial Assistance

Center for Family Medicine is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance.

Enclosed with this letter, you will find a worksheet/application that demonstrates your financial condition. You must complete this document in full and return all requested documentation **within 10 days** to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Center for Family Medicine, a portion of your account balance may be forgiven.

**In order to process this application we require:**

- **The enclosed application completed in its entirety (your application will NOT be processed if it is not completed)**
- **Copy of last two months of paystubs for any wage earner contributing to the household income**
- **Copy of your most recent 1040 tax return, including all applicable schedules, or proof of non-filing from the IRS (call 800-829-1040 to obtain this copy)**
- **One month documentation of bank statements (if you can provide tax documents)**
- **Two months documentation of bank statements (if you cannot provide tax documents)**
- **Social Security awards letters (if applicable)**

We realize that your income from previous tax records may not adequately reflect your current circumstances. Please attach a brief note that describes your current financial situation.

Once we have reviewed your application, we will notify you of our decision in writing within 10 days of the receipt. If you wish to discuss your account or have questions, please contact us at 605-339-1783. Our business office hours are Monday- Friday 8am-5pm.

Please respond to this request for information within 10 days and return to our office.

You can also email your documentation (pictures of documents are acceptable) to rose.fedt@c4fm.org and linda.hilt@c4fm.org. Please make sure the entire document is readable and not blurry.

Sincerely,

Center for Family Medicine
Business Office

# Center for Family Medicine

Financial Assistance Application

Name: _____ Account Number: _____

SSN: _____ Spouse: _____

Address: _____ SSN: _____

_____ Phone Number: _____

Number in Household: _____

Cash in Bank: $ _____

Stocks & Bonds: $ _____

Home Value: $ _____

Other Real Estate: $ _____

Cash on Hand: $ _____

Vehicles:

Year: _____ Value: $ _____ Make/Model: _____

Year: _____ Value: $ _____ Make/Model: _____

Other Investments/Savings: $ _____

| Monthly Income | Self | Spouse |
|---|---|---|
| Gross Income | $ | |
| Veteran's Pension | $ | |
| Disability | $ | |
| Retirement | $ | |
| Social Security | $ | |
| Unemployment | $ | |
| Work Comp | $ | |
| Alimony/Child Support | $ | |
| Rental Income | $ | |
| **TOTAL:** | $ | |

| Liabilities | Unpaid Balance | Monthly Payments |
|---|---|---|
| Name of Creditor: | $ | |
| Bank Loan | $ | |
| Auto Loan | $ | |
| Charge Cards | $ | |
| Doctors/Dentists | $ | |
| Hospitals | $ | |
| Collection Agencies | $ | |
| Alimony/Child Support | $ | |
| Other: | $ | |
| **TOTAL:** | $ | |

| Monthly Expenses | |
|---|---|
| Rent | $ |
| Food | $ |
| Insurance | $ |
| Clothing | $ |
| Phone | $ |
| Utilities | $ |
| Car Expenses (not pymnt) | $ |
| Medication | $ |
| **TOTAL:** | $ |

Do you anticipate receiving any gifts, inheritances or money from land sales or any other source in the near future? No ❑ Yes ❑

If Yes, please explain: _____

_____

Have you ever received any welfare benefits from any governmental or other third party source (county welfare, food stamps, Medicaid, Emergency Energy Assistance,etc)? No ❑ Yes ❑

If Yes, please state the nature of relief received and the time period that you received such benefits:

_____

_____

I (we) hereby acknowledge that the information given to Center for Family Medicine, Sioux Falls, SD as in the Financial Application indicated as true and correct and given for the purposes of obtaining credit, and authorizes release of information from my financial institution and creditors to the Center for Family Medicine or its representatives.

SIGNATURE: _____ DATE: _____

**Center for Family Medicine**
Financial Assistance

## APPROVAL

Date Approved: _____

PATIENT RESPONSIBILITY

Co-pay each visit: _____ Percentage Each Visit: _____

_____

_____

Effective Date: _____ Date Letter Sent to Patient: _____

## DENIAL

Date Denied: _____

Reason for Denial: _____

_____

_____

Effective Date: _____ Date Letter Sent to Patient: _____

## PAYMENT PLAN AGREEMENT

For Dates of Service: _____

Effective Date: _____

Balance Owed: _____

First Payment Date: _____ Each Month After: _____

Amount of Payment: _____ *monthly or bi-weekly* Payment Authorization Signed: _____

Your card will be automatically charged for the above amount, on the date specified above.

SIGNATURE: _____ DATE: _____

If payments are not made according to this agreement, we reserve the right to send the account(s) to collections.