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 to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Center for Family Medicine, part or all of your account balance may be forgiven.

In order to process this application we require:

- **The enclosed application completed in its entirety**
- **Copy of last two months of pay stubs for any wage earner contributing to the house hold income**
- **Copy of your most recent 1040 tax return, including all applicable schedules**
  If your most recent tax return is not available, then we need one of the following:
    1. **Social Security Awards Letter**
    2. **Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)**
- **Copy of your tax assessment statement from the county for any owned property**
- **Last two months documentation of bank statements.**

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, 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.

Center for Family Medicine
1115 East 20th street
Sioux Falls, SD 57105

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:

_____

_____

Proposed Payment Plan:

Please attach a copy of your most recent tax return

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: _____