Center for Family Medicine 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	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	Phone Number		
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 Under the Age of 18 (If more than 3 dependents use separate page)

Full Name	Relationship	Date of Birth (mm-dd-yyyy)
Full Name	Relationship	Date of Birth (mm-dd-yyyy)
Full Name	Relationship	Date of Birth (mm-dd-yyyy)

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

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
- ☐ Bank Statements - ALL Checking/Savings Accounts (Last 2 Months)
- ☐ Letter Explaining Circumstances if Other Documents Not Available
- ☐ Other: _____

MONTHLY EXPENSES

Rent	Insurance	Phone	Car Expenses
Food	Clothing	Utilities	Medication
Medical	Collection Agency	Alimony/Child Support	Credit Cards

TOTAL: _____

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

Primary Applicant: _____ Signature: _____ Date:_____

Secondary Applicant: _____ Signature: _____ Date:_____

Please return this application and supporting documentation within 10 days of receipt:
Mail to: **1115 East 20th Street, Sioux Falls, SD 57105** Email to: **rose.fedt@c4fm.org or linda.hilt@c4fm.org**

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PAYMENT PLAN AGREEMENT
Services Provided (Start/End)
Payment Plan Effective Date
Balance Owed
First Payment Date
Amount of Payment (monthly or bi-weekly)
Payment Authorization Signed

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

Primary Applicant: _____ Signature: _____ Date:_____

Secondary Applicant: _____ Signature: _____ Date:_____

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

Updated 2/6/2024