Winner Regional Health

745 E 8th Street
Winner, SD. 57580
Phone: (605) 842-7251
Fax: (605) 842-7173

FINANCIAL ASSISTANCE PROGRAM

In order to consider your application, please include copies of your most recent completed Federal Tax Return, last 3 months paystub's for all employed in household and a copy of your Property Tax Assesment. If on SSI, please provide a copy of your Social Security Award letter. Please return as soon as possible!

Circle: Single Married Separated Divorced Widowed

Last Name_____**First**_____**Middle**_____**Soc.Sec.#**_____

Address_____ City_____ State_____ Zip_____

Home Ph#_____ Work Ph#_____ Cell Ph#_____

Occupation_____ Employer_____ Hourly Wage_____ F/T or P/T

Spouse's Occupation_____ Employer_____ Hourly Wage_____ F/T or P/T

Please indicate ALL people living in your household: (use the back if necessary)

_____

_____

Total Household Income& How Often Received

Wages/Salary (gross)_____ Self-employment _____

Income from retirement_____ Income from Social Security_____

Income from Unemployment_____ Income from Workman's Comp_____

Child Support/Alimony_____ Other_____

Total Assets

Checking Account(s)_____ Savings Account_____

IRA's, 401K_____ Homestead Value_____

Other Property Value_____ Automobile(s) Value_____

Other Assets_____

Total Monthly Expenses	**Monthly**	**Outstanding Balance**
Bank Loan Payment(s)	$_____	$_____
Credit Card Payment(s)	$_____	$_____
House Payment	$_____	$_____
Rent Payment	$_____	$_____
Car/Truck Payment	$_____	$_____
Insurance Payment(s)	$_____	$_____
Child Support/Daycare	$_____	$_____

Utilities

Phone/Cable/Internet	$_____
Utilities	$_____
Cell Phone	$_____
Propane	$_____
Gas-Automobile	$_____
Groceries	$_____
Paid To Other Medical Bills	$_____
Prescriptions	$_____
Other (Please specify)	$_____

1. Have you ever declared **Bankruptcy**? ___YES ___NO If YES, when_____
2. Do you have any **judgments or liens** filed against you? If YES, please describe:_____
   _____
   _____

3. During the past 12 months, have you ever received any benefits such as welfare payments, food stamps, Medicaid, emergency assistance, County Poor Relief, Public Health Services, etc? If yes, describe_____
   _____

4. What is the approximate amount of **ALL** health bills you owe? (include hospital, clinic, and physicians):_____
   _____

5. What is the amount you pay towards your medical bills each month? $_____

Applying for financial assistance is NOT to be considered a substitute for personal financial responsibility, nor will it guarantee full or partial financial assistance. Patients are expected to cooperate with the

procedures for obtaining charity or other forms of financial assistance and to contribute to the cost of their care based on their individual ability to pay.

6. The total amount you owe Winner Regional Health $_____
    a. The amount you can pay Winner Regional Health each month $_____

7. Please include a short statement with any additional information you would like us to consider with your application, in regards to your personal and financial situation.

_____
_____
_____
_____

Assignment of Rights (Please Read Carefully)

By signing below I certify that the information and the statements contained in this application for financial assistance and the supporting documentation which I submit is accurate, true and correct to the best of my knowledge.

I understand that Winner Regional Health may make reasonable requests for additional information and verification if necessary.

I understand that the information and the statements I have provided will be kept confidential by Winner Regional Health.

I understand that I have the obligation to provide complete and truthful information to Winner Regional Health and to cooperate with any of the request for verification and additional information.

I understand that completion of this application will allow Winner Regional Health to consider my circumstances and makes NO representation that financial assistance is guaranteed.

Signature_____Date_____
Printed Name_____

FOR OFFICE USE ONLY	Approved	Denied
	Date	Date
	Signature	Signature