Financial Assistance

Madison Regional Health System is a 22 bed non-profit, independent, facility that has been serving Madison and the surrounding communities for over a century. We strive at providing the best care possible for our patients. We understand that bills associated with our services can often be a financial hardship. For this reason, we offer an opportunity for financial assistance within our healthcare system.

Applicants should apply for Medicaid and any other potential financial assistance programs before completing this application for financial assistance. If you are a resident of South Dakota, you must also apply for County Poor Relief before applying for financial assistance. You can apply for County Poor Relief at your local County Court House. If you have any questions regarding financial assistance or the information required on this application, please contact our Financial Counselor.

To help us better understand the circumstances surrounding your financial situation there is an application worksheet attached with this letter. In order for you to receive consideration for our financial assistance program you must complete the worksheet in full and return it with the items listed below to the Business Office at MRHS. If your conditions meet the criteria set by MRHS, part or all of your account balance may be forgiven.

Supporting documentation, please provide most recent copy available:

- **Enclosed Application**
- **Copy of your last pay stub(s)**
- **Bank Statements**
- **Tax Return (Federal, State if applicable)**
    - **If your most recent tax return is not available, then we will need one of the following:**
        - **Social Security Awards Letter**
        - **Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)**
- **W-2(s)**
- **Copies of all medical expenses**
- **Copy of your property tax assessment statement from county for all owned property.**

**The Business Office may request additional information as necessary for processing. **

We understand that income from previous tax documents may reflect a different income than your situation currently allows. If this is such the case please provide a brief letter explaining your current financial situation.

Once we have reviewed your application, you will receive notification of our decision in writing within 30 days of receipt. If you wish to discuss anything on your account, or have any questions please contact our Financial Assistance Counselor at 605-256-6551. Our business office hours are 8am-5pm Monday-Friday.

Please respond to requests for additional information within 30 days and return it to our office by mail at Madison Regional Health System, 323 SW 10th Street, Madison, SD 57042.

Thank you for your business.

Sincerely,

Madison Regional Health System

Madison
REGIONAL HEALTH SYSTEM

Return all applications to:

Madison Regional Health System
323 SW 10th Street
Madison, SD 57042-3200
(605)-256-6551

Financial Assistance Application

Demographic Information

Name	Date of Birth	Spouse	Date of Birth

Address	City	State	Zip

Time at Present Address: ___ Rent _____ Years _____ Months ___ Own	County	Marital Status _Married _Single _Divorced _Widowed

Cell Phone Number	Work Phone Number	Home Phone Number	Cell Phone Number	Work Phone Number

Please list ALL dependents living in your household: (Attach an additional sheet if needed)

Last Name	First Name	M	Date of Birth	SocialSecurity #	Relationship to Applicant
1 .					
2					
3 .					
4 .					

	Self		Spouse		
Social Security #			Social Security #		
Employed By			Employed By		
Business Address			Business Address		
Occupation		Hourly Wage	Occupation		Hourly Wage
How Long Employed: _Years _Months _Hours Worked Per Week			How Long Employed: _Years _Months _Hours Worked Per Week		

Additional Information

Have you ever declared bankruptcy? __No __Yes __Chapter 7 __Chapter 13 Date Filed: _____ Date of Discharge_____

Do you have any judgments or liens filed against you? If yes, please provide date and reason:

	Applicant Primary Insurance Coverage	Secondary Insurance Coverage	Spouse Primary Insurance Coverage	Secondary Insurance Coverage
Name:				
Address:				
Subscriber:				
ID & Group #				

Source of Income

Income: Represents total cash receipts from all sources before taxes.

	Self Monthly Gross		Spouse Monthly Gross
Gross Income		Gross Income	
Social Security/SSI/SSDI		Social Security/SSI/SSDI	
Public Assistance		Public Assistance	
Rental Income		Rental Income	
Retirement/Pension		Retirement/Pension	
Veterans Benefits		Veterans Benefits	
Unemployment/ Work Comp From: To:		Unemployment/ Work Comp From: To:	
Child Support/Alimony From: To:		Child Support/Alimony From: To:	
Other: Please Specify:		Other: Please Specify:	
TOTAL		**TOTAL**	

Combined Monthly Gross Income:

	Location	Amt/Value		Location	Amt/Value
Checking			Certificate of Deposit (CD)		
Savings			Stocks/Bonds		
Other			Other		

Assets/Property					
	Motor Vehicle	Year/Make/Model	Value	Loan Balance	Lien Holder
		Year/Make/Model	Value	Loan Balance	Lien Holder
	Recreational Equipment (boats, snowmobiles, etc.)	Year/Make/Model	Value	Loan Balance	Lien Holder
		Year/Make/Model	Value	Loan Balance	Lien Holder
	Other Property	Address, Township. County		Loan Balance	Assessed Value
		Address, Township. County		Loan Balance	Assessed Value
	Homestead	Address			Assessed Value
		Township, County		Mortgage Balance	Lien Holder

Monthly Expenses				
House Payment/Rent	Water and Sewer	Auto Insurance	Life Insurance	
Property Taxes	Phone/Cell Phone	Food	Health Insurance	
Property Insurance	Cable TV	Daycare Expense	Medications	
Heat	Vehicle Payment	Child Support Expense	Other/Specify	
Electric	Transportation Expense	Recreational Equipment	**TOTAL**	

Credit Cards/Other Expenses			
Creditor Name	**Address**	**Balance**	**Monthly Payment**
		TOTAL	
		GRAND TOTAL/CREDIT CARDS, OTHER EXPENSES AND MONTHLY EXPENSES	

How much of your MRHS bill are you currently paying/ or able to pay per month? _____

REQUIRED DOCUMENTS

– Proof of all income: (i.e. paystub(s), SS, SSI, SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Compensation, Child Support, Alimony, or any other forms of income).

_ Copy of your most recent tax return

_ Copy of your property tax assessment statement from county for all owned property.

ASSIGNMENT OF RIGHTS (Please Read Carefully)

I (We) hereby acknowledge that the information given to MRHS is true and correct. I (We) authorize MRHS to verify any of the information given by me (us). I (We) will provide documentation of this information upon request. I (We) also understand that if the information in which I (We) submitted is determined to be false, it will result in a denial of financial assistance and I (We) will be liable for charges for services provided.

Signature _____ Date _____

Signature _____ Date _____