

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 Signed & Dated**
- **Copies of the two most recent pay stubs for each wage earner in the household.**
- **Copies of last 1 months bank statements for all accounts (checking, savings, etc.)**
- **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.**
- **Copies to support assets values (mortgage statements, loan statements, etc.)**

\*\*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 10<sup>th</sup> Street, Madison, SD 57042.

Thank you for your business.

Sincerely,  
Madison Regional Health System



Return all applications to:

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

<b>Office Use Only:</b>
Account # _____
Date Received by Financial Office: _____

### Financial Assistance Application

Demographic Information	Name		Date of Birth		Spouse		Date of Birth	
	Address				City		State	Zip
	Time at Present Address: _____ Years _____ Months _____ Rent _____ 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		Social Security #	Relationship to Applicant
	1 .							
	2							
	3 .							
	4 .							
Additional Information	<b>Self</b>				<b>Spouse</b>			
	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			
	Have you ever declared bankruptcy? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chapter 7 <input type="checkbox"/> 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.							
	<b>Self Monthly Gross</b>				<b>Spouse Monthly Gross</b>			
	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				Unemployment/ Work Comp			
	From: To:				From: To:			
Child Support/Alimony				Child Support/Alimony				
From: To:				From: To:				
Other:				Other:				
Please Specify:				Please Specify:				
<b>TOTAL</b>				<b>TOTAL</b>				
<b>Combined Monthly Gross Income:</b>								
<b>Location</b>		<b>Amt/Value</b>		<b>Location</b>		<b>Amt/Value</b>		
Checking				Certificate of Deposit (CD)				
Savings				Stocks/Bonds				
Other				Other				

<b>Assets/Property</b>	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	
<b>Monthly Expenses</b>	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	<b>TOTAL</b>	
<b>Credit Cards/Other Expenses</b>	<b>Creditor Name</b>	<b>Address</b>	<b>Balance</b>	<b>Monthly Payment</b>	
			<b>TOTAL</b>		
<b>GRAND TOTAL/CREDIT CARDS, OTHER EXPENSES AND MONTHLY EXPENSES</b>					

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

**REQUIRED DOCUMENTS**

- Copies of the two most recent pay stubs for each wage earner in the household
- Copies of last 1 months bank statements for all accounts (checking, savings, etc.)
- Tax Return (Federal, State if applicable) (If not available: Social Security Awards Letter or Proof of non-filing from the IRS
- W-2(s)
- Copies of all medical expenses
- Copies of all property tax assessment statements from county for all owned property.
- Copies to support assets values (mortgage statements, loan statements, etc.)

**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 \_\_\_\_\_