Attachment B

PHILIP
HEALTH SERVICES

FINANCIAL ASSISTANCE PROGRAM

To ensure access to health care services provided by Philip Health Services, Inc., a Financial Assistance Program is provided for eligible patients who are otherwise unable to pay for these services. If approved, Financial Assistance will cover accounts up to 180 days from discharge.

Financial Assistance Program eligibility is based on Federal Poverty Income Guidelines, and financial ability to pay as determined through an application process. Elective procedures, long-term care, and Assisted Living Services do not qualify for the Financial Assistance Program.

The following documents must be included with your completed application:

- Documentation of income for 3 months – current pay stubs
- Completed Financial Statement – attached
- Tax Return – including ALL pages and ALL Applicable W-2's
- All documentation regarding unemployment and/or workers compensation, alimony, child support, WIC, Food stamps and/or other financial support.
- Copy of the last 3 months bank statements.
- Letter of Denial from South Dakota Public Assistance Program

CALL (605) 773-4678 TO APPLY BY PHONE FOR SD MEDICAID

Or login at http://www.dds.sd.gov

If you think you may be eligible for the Financial Assistance Program, you may request an application at the hospital business office, registration office, clinic office or online at www.philiphealthservice.com.

A written determination of your eligibility will be provided within 30 days of receipt of the completed application with all necessary supporting documentation.

To be eligible for 100% Financial Assistance Household Income must be at or below the Following Federal poverty guidelines.

Household Size	**Income** 100 % Write Off
1	$12,140.00
2	$16,460.00
3	$20,780.00
4	$25,100.00
5	$29,420.00
6	$33,740.00
7	$38,060.00
8	$42,380.00

Households above the Federal Poverty Guidelines, but below 200% may be eligible for Financial Assistance based on a sliding scale.

Household Size	**Income** 50% Write Off	**Income** 25% Write Off
1	$18,210.00	$24,280.00
2	$24,690.00	$32,920.00
3	$31,170.00	$41,560.00
4	$37,650.00	$50,200.00
5	$44,130.00	$58,840.00
6	$50,610.00	$67,480.00
7	$57,090.00	$76,120.00
8	$63,570.00	$84,760.00

If the amount owed Philip Health Services is 20% or less of your net worth, you will not be eligible for financial assistance.

FINANCIAL ASSISTANCE APPLICATION

Applicant (Guarantor) Information:

Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Social Security Number _____ - _____ - _____

Account(s) for which assistance is being requested:

Date of Service	Account #	Patient Name	Amount
		TOTAL	

Have you filed taxes, or were you claimed as a depended in the past 2 years? YES NO

If so, attach a copy of all pages of the return with all W2s or 1099s.

Do you or anyone in the household run a small business, farm or ranch? YES NO

If so, attach income statements and balance sheets for the previous 3 months

Household Size: (must be able to provide legal proof of member in household: ie tax return,court documents, marriage license, etc.)

#	Name	Relationship to Applicant	Date of Birth	Income Source

_____ Total Number in household

Household Income: (All household income must be reported)

Type	Monthly Amount	Annual Amount
Applicant Gross Wages		
Spouse Gross Wages		
Social Security		
Pension/VA/Railroad Retirement		
Workers Compensation		
Unemployment		
Child Support/Alimony		
Investments Income		

Expenses

Type	**Monthly Amount**	**Annual Amount**
Rent/Mortgage Payment		
Utilities		
Groceries		
Insurance		
Clothing		
Auto-Gas/Oil/Repairs		
Medical		
Other:		

Assets

Cash on hand:	
Bank Name:	
Checking Account Number	
Savings Account Number:	
Cash Value of Life Insurance:	
Home Market Value	
Other Real Estate Value	
Automobiles/RVs/ATVs:	
Other Investments:	
Personal & Other Misc.	
	Total:

Liabilities

Home Mortgage Balance:	
Other Real Estate Balance:	
Credit Card/Loan Balances:	
Medical/Dental Balances:	
Other Debt:	
	Total:

Net Worth

Total Assets:	
(minus) Total Liabilities:	
Net Worth:	

*Attach Small Business Balance Sheet when appropriate

I hereby request Philip Health Services, Inc. provide services to me, or my family member, without charge, or at a reduced charge, as may be determined in processing this application. I represent under oath, that I am unable to pay for services requested, and that all of the information submitted is complete and accurate, and may be subject to verification and review by state, federal and other enforcement agencies as required by law. I agree to provide to Philip Health Services, Inc. such additional information, as may be reasonably required, in order to substantiate my income, financial position, and ability to pay for services provided. I agree to release to Philip Health Services, Inc., their agents, and their employees from all liability arising out of their responsible efforts to verify the information I have provided as part of this application. I understand that my credit report may be used to verify this information. If I am entitled to any action or settlement from third party payers, I will take any action necessary or requested by Philip Health Services, Inc. to obtain such assistance and will assign to Philip Health Services, Inc. and upon receipt, will pay Philip Health Services, Inc. all amounts recovered up and to the total amount of the outstanding balance on my account.

Signature: _____ Date: _____

NOTE: Application must be returned by _____ to ensure eligibility!

HOSPITAL USE ONLY

Date Application Provided To Guarantor _____ Date Application returned:_____

Assistance Eligibility Level: _____% Assistance $ applied to accounts: $_____

Balance of accounts after assistance – Established on Payment Plan: $_____

Authorized Signature: _____ Date: _____