172 4th Street SE ✚ Huron, SD 57350
605-353-6200 ✚ 800-529-0115 ✚ 605-353-6300 fax
www.huronregional.org

HRMC
Huron Regional Medical Center

Dear Patient:

Huron Regional Medical realizes that payment of services may be a financial hardship at this time. Therefore, we are offering you the opportunity to apply for financial assistance.

Enclosed with this letter, you will find a financial assistance application that helps us determine your financial condition. Please complete this document in full to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Huron Regional Medical Center, part or all of your account balance may be forgiven.

In order to process this application we require:

- The enclosed form to be completed, signed and returned.
- Copy of the last 60 days of pay stubs for any wage earner contributing to household income.
- Complete copy of your most recent tax return, including copies of all schedules.
    - If you are self-employed, please include schedule C.
    - If you are a farmer, please include schedule F.
- If you do not file taxes and are eligible for Social Security,
    - Copy of your Social Security awards letter.
- Documentation from Social Services/Medicaid that there are no programs you or members of your household qualify for at this time.

We do realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note explaining your current financial situation.

If you choose not to return the financial assistance application or do not qualify for financial assistance, monthly payments of a predetermined amount will be needed to avoid further collection efforts.

Once we have reviewed your application, we will notify you of our decision in writing. Questions regarding your account can be directed to (605) 353-6223 or (605) 353-6593 or
1-800-529-0115, ext. 223 or 593. Our office hours are Monday through Friday from 7:00 a.m. - 5:00 p.m.

Sincerely,

HRMC Business Office

172 4th Street SE ✚ Huron, SD 57350
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FINANCIAL ASSISTANCE APPLICATION

In order to determine what type of payment plan will apply to your financial situation, we ask that you complete and return this form to Huron Regional Medical Center by:_____

Marital Status: Single Married Separated Divorced Widowed

APPLICANT/PATIENT

Name _____
Address _____
Social Security # _____-_____-_____
Current Employer _____
Hourly Wage _____

Home Phone /Cell_____
City/State _____ Zip _____
Date of Birth _____ /_____ /_____
Work Phone _____
Hours per Week _____

SPOUSE OR OTHER ADULTS OVER 18 LIVING IN HOUSEHOLD

Name _____
Address _____
Social Security # _____-_____-_____
Current Employer _____
Hourly Wage _____

Home Phone/Cell phone _____
City/State _____Zip_____
Date of Birth _____ /_____ /_____
Work Phone _____
Hours per Week _____

Please list all dependents living in your household:

Name	Date of Birth	Social Security #	Relationship to Applicant

Income/Assets

Total Monthly Household Income		Total Assets	Balance/Value
Wages/Salary (Gross)	$_____	Checking Account	$_____
Income from Self-employment	$_____	Bank:_____	
Income from Retirement	$_____	Savings Account	$_____
Income from Disability/SS	$_____	Bank:_____	
Income from Unemployment	$_____	Investments:	$_____
Income from Worker's Comp	$_____	(Non-retirement)	
Child Support/Alimony	$_____	IRA(s)	$_____
Monthly Food Stamp Amount	$_____	401K	$_____
Heating Assistance	$_____	Homestead Value	$_____
Rental Assistance	$_____	Other Property Value	$_____
Other Income	$_____	Automobile Value	$_____
		Boat, Camper, etc.	$_____
		Other Assets	$_____

Total Monthly Expenses

House Payment/Rent	$_____	Medical Bills	$_____
Property Taxes	$_____	Prescriptions	$_____
Property/Rental Insurance	$_____	Life/Health Ins.	$_____
Credit Cards	$_____	Groceries	$_____
Bank Loans	$_____	Other Expenses	$_____
Pay Day Loans	$_____	_____	
Rent to Own	$_____	_____	
Car/Truck Payments	$_____		
Auto Insurance	$_____		
Gas/other Auto expenses	$_____		
Child Support	$_____		
Daycare	$_____		
Phone/cell phone	$_____		
Cable TV	$_____		
Internet	$_____		
Electricity/Gas	$_____		
Water/Sewer/Garbage	$_____		

Additional Information:

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 provide date and reason: _____
3. During the past 12 months, have you received any benefits such as Medicaid, food stamps, emergency energy assistance, County Poor Relief, etc.? If yes please describe _____
4. What is the approximate amount of all outstanding medical bills you owe, (include, hospital, clinic, dental, etc.) _____
5. Do you have health insurance coverage? Yes/No. If so please provide a copy of your ID card.
6. Other comments: Please inform us of any additional information you would like us to consider with your application. _____

_____

ASSIGNMENT OF RIGHTS: Please read carefully:
By signing below I/we agree that the information and statements contained in this Application for Financial Assistance along with the supporting documentation which I/we submitted is accurate, true and correct to the best of my knowledge.
I/we understand that Huron Regional Medical Center may make reasonable requests for additional information and verification if necessary.
I/we understand that the information I/we have provided will be kept confidential by Huron Regional Medical Center.
I/we understand Huron Regional Medical Center makes no representation that financial assistance is guaranteed.

I/we hereby agree the above information is correct and I/we authorize Huron Regional Medical Center to verify this information.

___ I/we have enclosed copies of the last 60 days of pay stubs for all wage earners contributing to household income.
___I/we have enclosed a complete copy of the most recent tax return.

_____	_____	_____	_____
Patient Signature	Date	Spouse Signature	Date