



Attachment B

## **FINANCIAL ASSISTANCE PROGRAM**

To ensure access to healthcare 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 [www.dds.sd.gov](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](http://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 2026 Federal Poverty Guidelines.

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

For families/households with more than 8 persons, add \$5,680 for each additional person.

<u>Household Size</u>	<u>Income</u> <u>100 % Write Off</u>	<u>Household Size</u>	<u>Income</u> <u>50% Write Off</u>	<u>Income</u> <u>25% Write Off</u>
1	\$15,960.00	1	\$23,940.00	\$31,920.00
2	\$21,650.00	2	\$32,460.00	\$43,280.00
3	\$27,320.00	3	\$40,980.00	\$54,640.00
4	\$33,000.00	4	\$49,500.00	\$66,000.00
5	\$38,680.00	5	\$58,020.00	\$77,360.00
6	\$44,360.00	6	\$66,540.00	\$88,720.00
7	\$50,040.00	7	\$75,060.00	\$100,080.00
8	\$55,720.00	8	\$83,580.00	\$111,440.00

If your debt to 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 dependent 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 – for example, 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:* \_\_\_\_\_