Brookings HEALTH SYSTEM

Financial Assistance Application

Account #:_____ Balance: $_____

Name of Applicant: _____ SSN:_____

Name of Co-Applicant:_____ SSN: _____

Applicant's DOB: _____ Co-Applicant's DOB:_____

Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

Current Address:_____ City:_____ State: _____ Zip Code:_____

Former Address:_____ City:_____ State: _____Zip Code:_____
(if under 3 years at current)

Home Phone #:_____ Cell Phone #:_____

Work Phone #: Applicant_____ Co-Applicant_____

Applicant's Occupation:_____ Employer:_____ Years Employed:___

Co-Applicant's Occupation:_____ Employer: _____Years Employed:___

List ALL dependents under the age of 18 living in your household: (Use a separate sheet of paper if needed)

Name Date of Birth
SSN

1._____

2._____

3._____

4._____

5._____

Were you offered health insurance from your employer/ school? ____Yes _____No

If chose not to participate in a health insurance please explain:

_____

Were you denied health insurance from your employer/ school? ____Yes _____No

If yes please explain:

_____

Are you eligible for COBRA benefits? ___Yes ___No

Have you applied for Medicaid or other government assistance programs? ___Yes ___No

Are you uninsured? ___Yes ___No
If yes, you must submit a denial letter from Medicaid or Marketplace why you were denied coverage or provide an explanation of why there is no insurance coverage.

_____

Have you filed Bankruptcy? ___Yes ___No If yes, what was the date of filing/discharge _____

I(we) hereby acknowledge that the information given to the Brookings Health System, in this financial disclosure, is true and correct. I(we) authorize permission to the Brookings Health System to verify information contained herein. I(we) also understand that if the information which I submit is determined to be false, it will result in a denial of charity care status and that I will be liable for charges for services provided.

Signed_____ Date_____

Signed_____Date_____

Please provide the two most recent paystubs and two most recent tax returns for both the applicant and co-applicant for verification of income.

Submit

INTERNAL USE ONLY

Points_____ Percentage _____

Reviewed by: _____ Date: _____ Denied _____
Date_____

Approved by:_____ Date:_____ Denied by:_____
(Business Office Director)

CEO/CFO Signature:_____