BENNETT COUNTY HOSPITAL AND NURSING HOME

SERVING THE BENNETT COMMUNITY'S HEALTHCARE NEEDS

PO BOX 70, MARTIN, SOUTH DAKOTA 57551

TELEPHONE (605) 685-6622   FAX (605) 685-1166

===

Dear Patient:

As a small town hospital we are committed to this community and each and every resident's healthcare needs. To make sure no one is left behind we are offering a Financial Assistance Program. Depending on your family size and household income you may be eligible for up to a 100% reduction of your bill. You can check the chart below so see if you may be eligible. We will require you to provide us with income information. All the information provided will be kept strictly confidential. You will need to reapply each year to continue your financial assistance. Financial assistance runs from 180 days upon approval and can be relooked at any time if income levels change.

We currently only offer financial assistance for services at the Hospital. Nursing Home services provided within the walls of the nursing home, along with swing bed services, Physical Therapy, and Home Health are not covered by the financial assistance program. We can't offer a reduction on services sent outside the facility such as the reading of x-rays and certain labs as they are done by companies with their own billing practices. If you have any questions we encourage you to contact our CFO at 605-685-6622 ext. 1130.

Sincerely,

Board of Directors
Bennett County Hospital and Nursing Home and Bennett County Rural Health Clinic

Sliding Fee Guidelines for 2018

Family Size	This column is 100% of NFP	This column is 200% of NFP	This column is 300% of NFP
	If income is equal to or less then this column you are eligible for 100% discount	If income is equal to or less then this column and greater than the 100% discount column you are eligible for 75% discount	If income is equal to or less then this column and greater than the 75% discount column you are eligible for 50% discount anything 300% NFP may not be eligible
1	$12,140	$24,280	$36,420
2	$16,460	$32,920	$49,380
3	$20,780	$41,560	$62,340
4	$25,100	$50,200	$75,300
5	$29,420	$58,840	$88,260
6	$33,740	$67,480	$101,220
7	$38,060	$76,120	$114,180
8	$42,380	$84,760	$127,140
9+ FAMILY MEMBERS ADD $4,320 FOR EACH PERSON OVER 9			

Bennett County Hospital, Nursing Home and Rural Health Clinic
Serving the Bennett County Community's Healthcare Needs
PO Box 70 Martin, South Dakota 57551
Telephone (605) 685-6622 Fax (605) 685-1166

DATE: ______________________

LAST NAME OF RESPONSIBLE PERSON FIRST NAME INITIAL

SOCIAL SERCURITY NUMBER HOME NUMBER AGE

MAILING ADDRESS CITY STATE ZIP

EMPLOYER WORK PHONE NUMBER MONTHLY GROSS INCOME

LAST NAME OF SPOUSE/SIGNIFICANT OTHER FIRST NAME INITIAL

EMPLOYER WORK PHONE NUMBER MONTHLY GROSS
INCOME

RESPONSIBLE PERSON OTHER INCOME SPOUSE/SIGNIFICANT OTHER- OTHER INCOME ANNUAL GROSS
HOUSEHOLD INCOME

NUMBER OF CHILDREN IN FAMILY AGES OF DEPENDENT CHILDREN

Do you request an extended payment plan? □ YES □ NO

If yes, how much do you feel you can afford to pay each month? $____________________

A copy of the following information must be included with your application. Proof of income required.

- Federal Tax Return (Most recent) – if claimed as a dependent by someone else, must provide claimants most recent tax return
- 1 Months Current Pay Stubs- must include Responsible Person and Spouse/Significant Other
- 2 Months bank statements
- Copy of Medicaid card or denial letter from Medicaid stating you are not eligible for each individual listed below

Other Income Source- attach supporting documents

	Alimony		Food Stamps/Housing		Retirement		VA Assistance
	Child Support		Life Insurance		Social Security Insurance		Unemployment
	Disability		Pension		Worker's Compensation		Other

Please list all insurances for all individuals whose medical bills you are responsible, including Medicare, Medicaid, IHS, Blue Cross, etc.

NAME: ______________________________ NAME: ______________________________

INS #1. ______________________________ INS #1. ______________________________

INS #2. ______________________________ INS #2. ______________________________

INS #3.______________________________ INS #3. ______________________________

NAME: ______________________________ NAME: ______________________________

INS #1. ______________________________ INS #1. ______________________________

INS #2. ______________________________ INS #2. ______________________________

INS #3.______________________________ INS #3. ______________________________

NAME: ______________________________ NAME: ______________________________

INS #1. ______________________________ INS #1. ______________________________

INS #2. ______________________________ INS #2. ______________________________

INS #3.______________________________ INS #3. ______________________________

NAME: ______________________________ NAME: ______________________________

INS #1. ______________________________ INS #1. ______________________________

INS #2. ______________________________ INS #2. ______________________________

INS #3.______________________________ INS #3. ______________________________

I acknowledge the information given to Bennett County Hospital, Nursing Home & Rural Health Clinic is true and correct to the best of my knowledge. I acknowledge that falsifying any information in this packet may exempt me from al past and future charity care programs of the Bennett County Hospital, Nursing Home & Rural Health Clinic. I understand that I must reapply.

If you have questions, call our CFO 605 685 6622 ext. 1130

Responsible Person Signature: ________________________________ Date: ________________