Financial Assistance
Info & Application Form

Coteau des Prairies Health Care System is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance with our health system.

Enclosed with this letter, you will find a worksheet/application that demonstrates your financial condition. You must complete this document in full to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Coteau des Prairies Health Care System, part or all of your account balance may be forgiven.

In order to process this application, we require:

- **The enclosed application completed in its entirety**
- **Proof of all income (i.e. Last two pay stubs for any wage earner contributing to household income, SS, SSI, SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony, etc.)**
- **Copy of your most recent 1040 tax return, including all applicable schedules**
- **If your most recent tax return is not available, then we need one of the following:**
- **Social Security Awards Letter**
- **Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)**
- **Copy of your property tax assessment statement from county for any owned property**

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation. If a patient submits a completed financial assistance application during the Application period and CDPH determines that the patient may be eligible for participation in Medicaid or other governmental assistance programs, CDPH will notify the patient in writing of such potential eligibility and request that the patient take necessary steps to enroll in such program.

Once we have reviewed your application, we will notify you of our decision in writing within 30 days of receipt. If you wish to discuss your account or have any questions, please contact us at (605) 698-7647. Our business hours are Monday-Friday, 8am-4pm.

To Minnesota residents receiving service at Coteau des Prairies Health Care System facilities located in Minnesota: If you feel that, your concerns have not been addressed, please contact Coteau des Prairies Health Care System's Patient Financial Services at (605)698-7647 first and allow us the opportunity to try and address your concerns. If you continue to have concerns that have not been addressed, you may contact the MN Attorney General's Office at (651)296-3353 or (800)657-3787.

You may submit the completed form through our website OR return to our office by MAIL to Coteau des Prairies Health Care System, 205 Orchard Drive, Sisseton, SD 57262.

Thank you for your business.

Sincerely,

Coteau des Prairies Health Care System

Accounts: _____
_____
_____

Date Sent: _____
Return By: _____

Return all applications to:
Coteau des Prairies
Health Care System

205 Orchard Drive
Sisseton, SD 57262
(605) 698-7647

Financial Assistance Application

Demographic Information

Name	DOB	Spouse	Date of Birth

Address	City	State	Zip

Time at Present Address:	County	Marital Status
_____ Years _____ Months ___ Rent ___ Own		___ Married ___ Single ___ Divorced ___ Widowed

Please list ALL dependents living in your household: (Attach an additional sheet if needed)

Last Name	First Name	MI	DOB (mm/dd/yyyy)	Social Security #	Relationship to Applicant
1.					
2.					
3.					
4.					

Self		Spouse	
Social Security #		Social Security #	
Employed By		Employed By	
Business Address		Business Address	
Occupation	Hourly Wage:	Occupation	Hourly Wage:
How Long Employed: ___ Years ___ Months ___ Hours Worked/Week		How Long Employed: ___ Years ___ Months ___ Hours Worked/Week	

Additional Information

Have you ever declared bankruptcy? ___NO ___YES ___Chapter 7 ___Chapter 13 Date Filed: _____ Date of Discharge: _____

Do you have any judgments or liens filed against you? If yes, please provide date and reason: _____

	Applicant Primary Insurance Covg.	Secondary Insurance Covg.	Spouse Primary Insurance Covg.	Secondary Insurance Covg.
Name:				
Address:				
Subscriber:				
ID & Group #				

Source of Income

Income: Represents total cash receipts from all sources before taxes.

	Self Monthly Gross		Spouse Monthly Gross
Gross Income		Gross Income	
Social Security/SSI/SSDI		Social Security/SSI/SSDI	
Public Assistance		Public Assistance	
Rental Income		Rental Income	
Retirement/Pension		Retirement/Pension	

Veteran Benefits		Veteran Benefits	
Unemployment / Work Comp From: To:		Unemployment / Work Comp From: To:	
Child Support / Alimony From: To:		Child Support / Alimony From: To:	
Other Please Identify		Other Please Identify	
Total		**Total**	

Assets

205 Orchard Drive, Sisseton SD 57262 | (605) 698-7647 | cdphealth.com

	Location	Amt/Value		Location	Amt/Value
Checking			Certificate of Deposit (CD)		
Savings			Stocks / Bonds		
Other			Other		

Assets/Property

Motor Vehicle	Year / Make / Model	Value	Loan Balance	Lien Holder
	Year / Make / Model	Value	Loan Balance	Lien Holder
Recreational Equipment (boats, snowmobiles, etc.)	Year / Make / Model	Value	Loan Balance	Lien Holder
	Year / Make / Model	Value	Loan Balance	Lien Holder
Other Property	Address, Township, County		Loan Balance	Assessed Value
	Address, Township, County		Loan Balance	Assessed Value
Homestead	Address			Assessed Value
	Township, County	Mortgage Balance		Lien Holder

Monthly Expenses

House Payment / Rent	Water and Sewer	Auto Insurance	Life Insurance
Property Taxes	Phone / Cell Phone	Food	Health Insurance
Property Insurance	Cable TV	Daycare Expense	Medications
Heat	Vehicle Payment	Child Support Expense	Other / Specify
Electric	Transportation Expense	Recreational Equipment	**Total**

Credit Cards/Other Expenses

Creditor Name	Address	Balance	Monthly Payment

		Total	
		GRAND TOTAL / CREDIT CARDS, OTHER EXPENSES AND MONTHLY EXPENSES	

How much of your CDP bill are you paying/or are able to pay per month? _____

Required Documents

205 Orchard Drive, Sisseton SD 57262 | (605) 698-7647 | cdphealth.com

- ☐ Proof of all income: (i.e. 2 paystubs for each wage earner, SS, SSI, SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony, or Other).
- ☐ Copy of your most recent 1040 tax return, including all applicable schedules.
- ☐ Copy of your property tax assessment statement from county for all owned property.

ASSIGNMENT OF RIGHTS (Please Read Carefully)

- By signing below, I certify that the information and statements contained in this Application for Financial Assistance and the documentation which I submit are accurate, true and correct to the best of my knowledge.
- I understand that Coteau des Prairies Health Care System may make reasonable requests for additional information and verification if necessary.
- I understand that the information and statements I have provided will be kept confidential by Coteau des Prairies Health Care System.
- I understand that the completion of this application will allow Coteau des Prairies Health Care System to consider my circumstances.
- I understand Coteau des Prairies Health Care System makes no representations that financial assistance is guaranteed.

I/We hereby certify the above information is correct and voluntarily authorize you to obtain credit information relative to me/us.

_____ _____ _____ _____

Signature Date Signature Date