LifeScape

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FINANCIAL ASSISTANCE APPLICATION
Required Documentation Checklist

Please use this form to assist you in returning the items below, as they apply to your situation. These items are required to process your application for financial assistance.

Please note that your application will be denied if all required documentation is not supplied. Please refrain from using correction fluids.

_____ Federal Income Tax Return (1040, W2, and all schedules that apply).

_____ Pay stubs for a period of 13 weeks prior to date of service. (_____ to _____)

_____ Letter of Support, if you have zero income (Attachment B.)

_____ Unemployment Benefits: Either the check stubs for 13 weeks or loops printout.

_____ VA Pension Benefits Letter for the year prior to your visit.

_____ Social Security Benefits Letter for the year prior to your visit.

_____ Child Support and/or Alimony documentation.
If through the Probation Office, please supply the Child Support or Alimony Case #: _____

_____ General Assistance: Copy of your Medicaid card, letter from your case worker stating when you started receiving, amount, and if the case is still open. (Note: This letter can be provided to you if you need to take to your case worker.

_____ Bank Statements (checking and/or savings) the month of your visit which must reflect a balance on the date of your service.

_____ All assets, which include 401k, stock, bonds, IRA, and real estate other than your primary residence.

_____ One form of identification for all immediate family members that are listed on this application (Example: driver license, birth certificate, or social security card.)

_____ A copy of all insurance cards.

_____ Proof of residency on the date of your service (example: driver license, lease, utility bill, rent receipt, etc.) Your name and address must appear on this document.

_____ Self-employed patient: Please provide a profit & loss statement for the three months prior to your visit. This must be completed by an accountant or local tax service.

_____ Other Required Info: _____

Contact Information for Support and Assistance

To speak with someone in the billing department regarding Financial Assistance, please call any of the phone numbers below:

Name	Phone Number	Email Address
Amy Jensen	(605) 444-9711	amy.jensen@lifescapesd.org
Lisa Amundson	(605) 444-9723	lisa.amundson@lifescapesd.org
General Phone Line	(605) 444-9700	Fax: (605) 444-9706

Completed applications can be faxed or mailed.

Our mailing address is:
LifeScape Rehabilitation Center
Attn: Lisa Amundson
1020 W 18th Street
Sioux Falls SD 57104

APPLICATION FOR PARTICIPATION

Proof of Identification, Income and Assets must accompany this application. Send copies of all requested documents.

*Do **not** send original documents, as they will not be returned.*

SECTION I – Personal Information

Patient Name (Last, First, MI)			
Street Address			
City, State, Zip Code			
Telephone Number			
Date of Application		Social Security Number:	- -
Date of Service		Requested Date of Service:	
Name of Guarantor	(If other than patient)		Family Size**:

SECTION II – Assets Criteria

Individual Assets		
Family Assets		
Assets Include		
	Cash	
	Savings Account	
	Checking Accounts (Bank or Credit Union)	
	Certificates of Deposit (CD's)/IRA/401k	
	Equity in Real Estate (Other than Primary)	
	Other Assets (Treasury Bills, Negotiable Paper, Corporate Stocks/Bonds)	
Total		

**Family size includes self, spouse, and any minor children. A pregnant woman is counted as two.

SECTION III – Income Criteria

When determining eligibility for hospital care assistance, a spouse's income and assets must be used for an adult; parent(s) income and assets must be used for a minor child.

*Proof of Income and Assets **must** accompany this application.*

Income is based on the calculation of twelve months, three months, or one month of income prior to the date of service (whichever is to the applicants' benefit.)

Patient / Family gross Income equals the lesser of the following:

The Last 12 Months OR Last 3 Months x 4 OR Last 3 Months x 12

Sources of Income

	Weekly	Monthly	Yearly
Salary/Wages before deduction			
Public Assistance			
Social Security Benefits			
Unemployment/Workers Compensation			
Veterans Benefits			
Alimony/Child Support			
Other Monetary Support			
Pension Payments			
Dividends/Interest			
Rental Income			
Net Business Income (Self Employed needs independent verification.)			
Other (Strike benefits, training stipends, military family allotment, income from Estates and Trusts.)			
TOTAL			

SECTION IV – Certification by Applicant

I understand the information which I submit is subject to verification by the appropriate health care facility and the Federal or State Governments. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties.

If so requested by the health care facility, I will apply for governmental or private medical assistance for payment of the bill.

I certify the above information regarding my family size, income, and assets is true and correct.

I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.

Signature of Patient or Guarantor _____ **Date** _____

LIFESCAPE MEDICAL CENTER FINANCIAL QUESTIONNAIRE

I. ASSETS

Bank Name		Branch Location	
Checking Account #		Balance	
Savings Account #		Balance	
Other Assets:		Balance	
		Balance	
		Balance	
		Total Assets	

II. TOTAL NUMBER OF DEPENDENTS (including yourself) _____

Dependent's Name	Date of Birth	Social Security Number

Please answer the following questions:

Is this service due to a work or Auto related injury? No Yes

Are you currently pending S.S.I.? No Yes Date Filed: _____

Is there litigation pending? No Yes

I understand the information which I submit is subject to verification by LifeScape and Federal and State governments. Willful misrepresentation of these facts will make me liable for all hospital charges. If so requested by LifeScape, I will apply for government or private assistance for the payment of this hospital bill. I further understand that LifeScape will conduct a credit check with Credit Bureau Associates in order to assist in determining my ability to pay.

I certify that the above information regarding my family size, income, and assets is true and correct.

_____ _____

Patient/Guarantor Signature Date

_____ _____

Spouse/Power of Attorney (Documentation needed) Date

To whom it may concern:

I/We do hereby authorize and request the disclosure of LifeScape, their agent, representative or bearer to inspect, review, copy including Photostat copies of all records pertaining to my age, residence, citizenship, employment, income, resources, health records, and any Social Security Benefits. It is understood that the information obtained be used for purposes directly related to my eligibility for Charity Care.

Photostat copies of this authorization will be considered as valid as the original.

_____ _____

Patient/Guarantor Signature Date

Hospital Assistance is free or reduced charge care and is provided to patients who receive either inpatient or outpatient services. Hospital assistance and reduced charge care is available only for necessary hospital care and does not cover physicians or prescription drugs.

_____ _____

Patient/Guarantor Signature Date

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To Whom It May Concern;

I, _____ attest that I provide(d) the necessary room, board, and other life essentials

for _____ at my residence _____

_____

from ___/___/___to ___/___/___or present. (Please indicate which.)

My relationship to the above patient(s) is that of:

_____

I understand that signing this does not make me financially responsible for any debt and that this form only establishes support.

_____ _____

Patient/Guarantor Signature Date

Telephone Number: ( ) _____

Please note: The person signing this attestation must also include a copy of their ID.

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PLEASE SIGN ALL APPLICABLE STATEMENTS

☐ I attest that I have no income and have had no income from ___/___/___to ___/___/___

_____	_____	_____
Signature of Patient/Guarantor	Signature Of Spouse/Other	Date

☐ I attest that I have no assets as listed on my Charity Care Application through myself or any other party. This also applies to any minor children in the household.

_____	_____	_____
Signature of Patient/Guarantor	Signature Of Spouse/Other	Date

☐ I attest that I am homeless and have been homeless since ___/___/___

_____	_____	_____
Signature of Patient/Guarantor	Signature Of Spouse/Other	Date

☐ I attest that I have no medical coverage through myself or any other party to cover the outstanding amount of this bill.

_____	_____	_____
Signature of Patient/Guarantor	Signature Of Spouse/Other	Date

☐ I attest that I have not filed any income tax returns for the year(s) of _____ to _____.

_____	_____	_____
Signature of Patient/Guarantor	Signature Of Spouse/Other	Date