Dakota Eye Institute
the Ones to See
WWW.DAKOTAEYE.COM

NORTH CLINIC
3119 N 14TH ST
BISMARCK, ND 58503
tel: 701.222.3937
fax: 701.222.8805

SOUTH CLINIC
200 S 5TH ST
BISMARCK, ND 58504
tel: 701.222.3937
fax: 701.222.8805

SURGERY CENTER
430 E SWEET AVE
BISMARCK, ND 58504
tel: 701.222.4900
fax: 701.222.4999

LINTON CLINIC
114 BRDWY ST N #1
LINTON, ND 58552
tel: 701.254.4450
fax: 701.254.4550

Financial Assistance

Dakota Eye Institute and Dakota Surgery and Laser Center ("DEI") are 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 clinic and surgery center.

Please complete the attached application. 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 DEI, part or all your account balance may be forgiven.

In addition to a completed application, please provide the following:

- **Copy of your most recent Federal 1040 tax return, including all applicable schedules OR Proof of non-filing from the IRS (go to the IRS website at www.irs.gov)**

  AND ONE OF THE FOLLOWING:

- **Copy of last two pay stubs for any wage earner contributing to household income**

- **Social Security Awards Letter or most recent 1099 if receiving Social Security (If you are receiving Social Security as well as have other income, please provide proof of additional income)**

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 along with any pertinent changes.

Once we have reviewed your application, we will notify you of our decision within 30 days of receipt. If you wish to discuss your account, please contact Patient Financial Services at 701.222.1002. Our business hours are Monday – Thursday 8am – 5pm and Friday 8am – 3pm.

Please respond to this request for information within 30 days and return to our office by **SECURE FAX** at (701)751-3555 or **MAIL** to Dakota Eye Institute, 200 S 5th St, Bismarck, ND 58504.

Thank you for your business.

Sincerely,

Dakota Eye Institute and Dakota Surgery and Laser Center

Financial Assistance Application

Demographics

Name_____ Date of birth _____

Spouse's name _____ Date of birth _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address _____City _____State_____ Zip code _____

Cell (self) _____ Cell (spouse)_____ Home _____

Please, list all dependents under the age of 18 living in the household.

Name_____ Date of birth _____ Name _____Date of birth_____

Name_____ Date of birth _____ Name _____Date of birth_____

Name_____ Date of birth _____ Name _____Date of birth_____

Income

Self	Monthly Gross Income	Spouse
$	Gross income/Unemployment/Work Comp.	$
$	Social Security/SSI/SSDI	$
$	Self-employment/Rental income/Royalties/Estates/Trusts	$
$	Retirement/Pension/Annuities/Veteran's benefits	$
$	Child support/Spousal support/Public assistance	$
$	Miscellaneous/other income:_____	$
$	**Total income (please provide proof of all income)**	$

How much of your DEI bill are you paying/or can pay per month? _____

Assignment of Rights (Please Read Carefully)

By signing below, I certify that the information on this application and the supporting documentation are true and correct to the best of my knowledge. I understand the information is kept confidential and I may be requested to supply additional information. I understand my application for financial assistance cannot be reviewed unless all the information requested is provided. DEI has made no representations that financial assistance is guaranteed.

Name (print)_____Signature _____Date_____

Spouse (print)_____Signature _____Date_____