Prairie Community Hospital District
312 South Adams Ave.
P.O. Box 156
Terry, MT 59349

Financial Assistance Application

1. Patient's Information: *(Social Security Number and Marital Status are optional.)*

____
Last Name *First Name* *Middle Initial* *Social Security Number* *Date of Birth*

____
Street Address *City* *State* *Zip code*

____
Mailing Address *City* *State* *Zip code*

____ *check one:* ☐Single ☐Married
Home Phone Number *Work Phone Number* ☐Separated ☐Divorced ☐Widowed

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2. Person Responsible for Paying the Bill

____
Last Name *First Name* *Middle Initial* *Social Security Number*

____
Address if Different from Patient's *Home Phone Number* *Work Phone Number*

____
Name of Insurance Company *Effective Date*

3. **Please indicate ALL people living in the household, including applicant: Use an additional sheet of paper if needed

NAME	*RELATIONSHIP TO PATIENT*	*DATE OF BIRTH*	*SOC. SECURITY#*	*DOCTOR'S NAME*
1				
2				
3				
4				
5				

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4. Is this application for future or past services? ☐ Future ☐ Past Date(s) of Services: __________________________

5. Has anyone in your household served in the military? ☐ Yes ☐ No Who: ____________________________________

6. Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No Who: ____________________________

7. Does anyone else claim you on their income tax return? ☐ Yes ☐ No Who: ___________________________________

Prairie County Hospital District is an equal opportunity medical provider and employer.

12. HOUSEHOLD INFORMATION	PERSON 1	PERSON2	PERSON3
***NAME of each household member:**	__________________	__________________	__________________
Name of employer:	__________________	__________________	__________________
Monthly Income From:			
Employment:	$__________________	$_________________	$_________________
Self-Employment:	$__________________	$_________________	$_________________
Investment Interest :	$__________________	$_________________	$_________________
Real Estate rental Income:	$__________________	$_________________	$_________________
Unemployment: (since (___/___/___)	$__________________	$_________________	$_________________
Retirement: (Soc. Security, Pension, Annuity)	$__________________	$_________________	$_________________
Alimony/Child Support:	$__________________	$_________________	$_________________
Public Assistance, Food Stamps:	$__________________	$_________________	$_________________
Other Income:	$__________________	$_________________	$_________________

13. ASSIGNMENT OF RIGHTS Read this section carefully and sign.

I agree to tell this facility about changes to my status including household size, income and insurance coverage that could change my eligibility or need for financial assistance.

I certify that the above information is true and accurate to the best of my knowledge If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate at their discretion.

I understand that this facility cannot share confidential information with any state or federal agency without my prior approval.

____

Signature of Applicant (Patient or Guarantor) Date

____

Signature of Authorized Representative Date

If you have any questions about this application, contact the Business Office at (406) 635-5511.
Mail your completed application to:

Prairie Community Hospital
Financial Assistance
P.O. Box 156
Terry, MT 59349

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Addendum A

Documentation Checklist:

- Signed and dated application for financial assistance
- Proof of Household – Two (2) forms of identification for the patient/guarantor and one (1) form of identification for all other household members. You may use a birth certificate, driver's license, passport, Social Security card, or other government issued ID.
- Proof of all Household Income as listed on the application, including federal income tax returns, pay stubs, child and/or spousal support, public assistance, unemployment benefits, Social Security benefits, pension statements, interest or dividend statements, and any other income for the household.

Please provide copies of all requested documents. **Do not** send originals through the mail. If you do not have access to a copier, you can bring all the documents to the office and a Financial Counselor will make the copies for you.

If you have any questions, please do not hesitate to call the Business Office at (406) 635-5511.