



PRAIRIE LAKES
Healthcare System

Prairie Lakes Healthcare System is committed to providing health care to all people of our area who are in need of such services, without regard to their ability to pay.

Attached please find an application to see if you would qualify for financial assistance on your outstanding accounts at Prairie Lakes Healthcare. This is an internal program, to help with unexpected financial burdens, based on assets, income and expenses. This application and policy are also located on our website at www.prairielakes.com.

In order for your application to be processed upon receipt, please provide all requested information with your application.

- Complete Federal Tax Return (most recent) including all schedules or verification of an IRS non filing letter.
- Copy of one month's current paycheck stubs for each income listed.
- Three months of complete current bank statements.
- Social Security Income Verification (if applicable).
- Unemployment verification (if applicable).
- Medicaid denial (if applicable)
- Copy of Death Certificate (if applicable)

Your application will not be considered until we receive all supporting documentation.

If you have any questions, please contact us.

Patient Account Specialists

Lynette or Vicky 605-882-7883

Fax: 605-882-7697

Prairie Lakes Healthcare
P.O. Box 1210
Watertown, SD 57201
www.prairielakes.com



FINANCIAL ASSISTANCE DISCLOSURE STATEMENT

Date _____

Name _____
Spouse _____
Account # _____
Address _____
Dependants _____
Patient Employment/Start Date _____
Spouse Employment/Start Date _____
Home Phone # _____
Cell Phone # _____

MONTHLY INCOME:

Wages or Salary (gross)	\$ _____
Income from Self Employment	\$ _____
Income from Farm	\$ _____
Social Security Income	\$ _____
Unemployment Benefits	\$ _____
Alimony	\$ _____
Child Support	\$ _____
Other (please specify)	\$ _____
TOTAL	\$ _____

CASH ASSETS:

Checking Balance	\$ _____
Savings Balance	\$ _____
Other (CD'S, Bonds, Etc)	\$ _____
TOTAL	\$ _____

MONTHLY EXPENSES:

	Monthly Payment	Unpaid Balance
House Payment/Rent	\$ _____	\$ _____
Vehicle Payment(s)	\$ _____	\$ _____
Credit Card Bills	\$ _____	\$ _____
Other Bank Loans	\$ _____	\$ _____
Insurance Payments		
Medical Insurance	\$ _____	\$ _____
Vehicle Insurance	\$ _____	\$ _____
Home Insurance	\$ _____	\$ _____
Utilities (electric, gas, garbage, water)	\$ _____	\$ _____
Internet	\$ _____	\$ _____
Cable	\$ _____	\$ _____
Home Phone	\$ _____	\$ _____
Cell Phone	\$ _____	\$ _____
Car Expense (repair and gas)	\$ _____	\$ _____
Dining Out Expense	\$ _____	\$ _____
Grocery/Personal Items	\$ _____	\$ _____
Monthly Medication	\$ _____	\$ _____
Other Medical Bills	\$ _____	\$ _____
Child Support	\$ _____	\$ _____
Daycare	\$ _____	\$ _____
Other (not covered above)	\$ _____	\$ _____
Total Expenses	\$ _____	\$ _____

NON CASH ASSETS:

House Value	\$ _____
Mobile Home Value	\$ _____
Land Value	\$ _____
Livestock Value	\$ _____
Vehicle _____ #1	\$ _____
Year and _____ #2	\$ _____
Make _____ #3	\$ _____
Boat / Jet Ski Value	\$ _____
Camper Value	\$ _____
Motorcycle / Snowmobile Value	\$ _____
Other (describe) _____	\$ _____
TOTAL	\$ _____

******ATTACH A COPY OF YOUR MOST RECENT FEDERAL INCOME TAX RETURN INCLUDING ALL SCHEDULES, A COPY OF ONE MONTH CURRENT PAYSTUBS FOR EACH INCOME LISTED, AND 3 MONTHS COMPLETE CURRENT BANK STATEMENTS******

I authorize Prairie Lakes Healthcare to verify any information given on this application. I understand that if asked, I will submit other documentation such as pay check stubs, Social Security Income, unemployment verification, or personal property tax receipts. By signing below I agree the information given is complete and accurate to the best of my knowledge.

Signature _____ Date _____