Application for Self-Pay Discount

Patient Account Number _____

I hereby request Prairie Ridge Hospital and Health Services (PRHH) to make a determination of eligibility for the PRHHSPD. I understand that the information submitted on this application and the documentation I submit to verify household income is subject to verification by PRHH. This application is made pursuant to the terms and conditions of the PRHHSPD as described in the foregoing informational statement. I represent to PRHH that I do not have any insurance, third party payer resources or government-supported programs to cover PRHH charges. I understand PRHHSPD is available only for medically necessary health care treatment.

PATIENT AND HOUSEHOLD MEMBER INFORMATION

Name of Patient _____ Patient D.O.B_____

Name of Applicant(Guarantor)_____

Address_____ Phone_____

Applicant's Occupation_____ Employer_____

Employer's Phone_____ Employer Contact_____

Gross Annual Income_____ Name of Spouse_____

Spouse's Occupation_____ Spouses Employer_____

Employer Phone_____ Employer Contact_____

Gross Annual Income _____Applicant Social Security # _____

Spouses Social Security #_____

Name and Age of All Household Members_____

Other Household member(s) occupation_____

Employer Phone_____Employer Contact_____

Gross Annual Income_____ Employer Phone_____

Employer Contact_____ Gross Annual Income_____

Employer Phone_____ Employer Contact _____

Gross Annual Income_____

DISCLOSURE OF ALL HOUSEHOLD INCOME

Income is the total of all household member earnings, income and money receipts before taxes from all sources including wages, salaries, unemployment, social security, alimony, investments, rents, public assistance, self-employment, farm or business, etc.

INCOME: Gross Income for Household: Income from all members of the household must be included.

Wages (before taxes). . . . . _____
Farm or Self-employment . . . . . _____
Public Assistance . . . . . _____
Social Security . . . . . _____
Unemployment Compensation . . . . . _____
Worker's Compensation . . . . . _____
Disability . . . . . _____
Alimony . . . . . _____
Child Support . . . . . _____
Pensions . . . . . _____
Income from Dividends, Interest, Rent . . . . . _____
Other Sources of Income. . . . . _____.

TOTAL ANNUAL HOUSEHOLD INCOME **_____**

Please provide the following income verification documents for each applicable family member and sign the certification statement below:

1) **Copy of the most recent Federal tax return (1040 or 1040EZ)**
2) **Copy of 3 months of the most recent pay stubs for all employed family members or self-employed income.**
3) **Copy of 3 months of most recent checking and/or savings bank statements**

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by PRHH, and I authorize PRHH to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the bill(s).

I, THE UNDERSIGNED AGREE THAT THIS APPLICATION CONSTITUTES A WRITTEN AGREEMENT BY APPLICANT TO PAY THE AMOUNT OF THE CHARGES REMAINING AFTER MAKING THE APPLICABLE DEDUCTION UNDER THE PRHHSPD, IF THE PRHHSPD IS AWARDED.

Applicant's Signature: _____

Date: PRHH/12102019