Douglas County Memorial Hospital
708 8th Street
Armour, SD 57313
Phone (605) 724-2159 – Fax (605) 724-2310

Prairie Health Clinics

Armour
708 8th St
Phone (605) 724-2151
Fax (605) 724-2310

Corsica
PO Box 22
Phone (605) 946-5959
Fax (605) 946-5616

Stickney
PO Box 14
Phone (605) 732-4508

Wagner
310 W SD Hwy 46
Phone (605) 384-4577
Fax (605) 384-4579

CONFIDENTIAL FINANCIAL ASSISTANCE QUESTIONAIRE

Patient Name:_____ Account Number(s):_____

APPLICANT INFORMATION

Applicant's Full Name			Date of Birth
Address		City, State, Zip	
Social Security Number	Telephone	Number of Dependents	
Employer	Position	Length of Employment	Gross Wages/Month
Employer Address	City, State, Zip		Telephone
Income of Other Adults in Household	Source		Amount/Month
Other Sources of Income	Amount/Month	Bank Name/Address	

Asset	Amount	Liabilities	Amount
Cash		Other Medical (Detail)	
Investments (Describe)		Credit Card Debt	
Home (Current Value)		Home Mortgage(s)	
Other Real Estate			
Vehicles (Year, Make, Model)		Auto Loans	

Business (Net Assets)		Business Loans	
Other (Describe)		Other Debt (Describe)	

Please attach a copy of your most recent federal tax return along with last two paystubs. You may be required to apply for Medicaid assistance before your request for charity care can be approved.

Please check any that apply:

_____ Applicant/patient is not eligible for Medicare, Medicaid or Veteran's benefits

_____ Applicant/patient cannot afford private health insurance

_____ Applicant/patient employer does not offer health insurance benefits

_____ The patient is not covered by any health insurance plan

Patient Insurance Coverage (if applicable):

Insurance Company Name	Group Number	Subscriber/Member ID	
Deductible	Co-Insurance	Maximum out of Pocket	Insurance Company Address

List all members of the household, starting with the PATIENT:

Name	Relationship to Patient	Age
1		
2		
3		
4		
5		
6		
7		
8		

I certify that the information in this application is true and complete.

_____ _____

Signature of Applicant **Date**