

**St. Aloisius Medical Center
325 Brewster St E, Harvey ND 58341
Caring Program Application**

Date of Request: _____

I _____ hereby request that St. Aloisius Medical Center (SAMC) make a determination of my eligibility for caring program services at SAMC. I understand that the information which I submit will be subject to verification by SAMC, and if the information which I submit is determined to be false, it will result in a denial of caring program services. All alternative payment resources must have been exhausted which includes application for any public assistance programs such as Medicaid. Copies of denials may be required as proof of application.

Services not eligible for the caring program include but are not limited to: Non Medically Necessary Services, services billed by separate entities (i.e. radiologist, etc.) and balances designated as recipient liability under the Medicaid program.

1. Name: _____
First Middle Last
 Address: _____
Number and Street City State Zip Code
 Date of birth: _____ Marital Status: Single Married Widow Divorced
 Telephone: _____ Cell Phone: _____
 Occupation: _____
 Employer: _____ Phone: _____

2. Spouse Name: _____
First Middle Last
 Occupation: _____
 Employer: _____ Phone: _____

3. Income: **A) List total gross income for household/residence below.**
 B) You must provide a copy of your most recent Federal Income Tax return (or complete a Form 4506-T to verify that you did not file Federal Income Tax)
 C) Or provide us with verification of income for the last 3 months

Total For Last 12 Months

<u>Self</u>	<u>Spouse/Supporting Household Member</u>
Wage Income.....	Wage Income.....
Farm or Self-Employment.....	Farm or Self-employment.....
Social Services (Food Stamps, AFDC, etc.)....	Social Services (Food Stamps, AFDC).....
Social Security.....	Social Security.....
Unemployment Compensation.....	Unemployment Compensation.....
Worker's Compensation.....	Worker's Compensation.....
Strike Benefits.....	Strike Benefits.....
Alimony.....	Alimony.....
Child Support.....	Child Support.....
Military Family Allotments.....	Military Family Allotments.....
Pension.....	Pension.....
Income from Dividends, Interest, Rent.....	Income from Dividends, Interest, Rent.....
Other.....	Other.....
Sub Total _____	Sub Total _____

TOTAL: _____

Caring Program Application, cont.

4. **Assets:**

Land & Real Estate.....

* Do you own a home on up to 160 acres or more out of town (homestead exemption), or more than two acres in town? Y / N

* Do you have more than \$3,000.00 in other real estate property? Y / N

Saving Account(s)/CD=s.....

* Do you have more than \$2,000 in liquid assets (1 person), \$3,500 (2 people), additional \$500/person? Y / N

Other Assets.....

* Do you own more than one motor vehicle per licensed adult? Y / N

Licensed adult = age 18 and over

* Do you have recreational vehicles (snowmobiles, ATV, jet skies, etc)? Y / N

If you answered yes, please list what type: _____

and how many: _____

5. **Health Insurance:** Do you have any type of health insurance such as Blue Cross, Medicare, Medicaid, or commercial insurance? Yes No If yes, please specify below:

Insurance name _____ Policy # _____

Insurance name _____ Policy # _____

6. **Dependents:**

Name

Relationship

Age

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If additional room is needed, please use the back of this page)

Dependents over 18 must show proof of disability and verification of income

7. **Type of Health Care Services Received:** _____

I affirm that the information listed in this request is true and correct to the best of my knowledge. I hereby authorize St. Aloisius Medical Center to investigate any information provided and I authorize the release of any information that SAMC deems necessary in making an eligibility determination.

Signature (Person Making Request)

Date

TO BE COMPLETED - FACILITY PERSONNEL ONLY

This document was received on _____ by _____