



Application For Financial Assistance

Pembina County Memorial Hospital / CliniCare’s policy requires that an individual must complete and return this application along with the following information prior to receiving financial assistance.

Attach a copy of the following:

- a. **Most current federal income tax return**
- b. **Income verification- Paycheck stubs and bank statements from the last 3 months OR a copy of social security award letter(s) and last 3 months’ bank statements.**

Date Application Sent: _____

Guarantor’s Name: _____

Address: _____, _____, _____
City State Zip

Hospital/CliniCare

Account: _____ Balance Due: _____
Account: _____ Balance Due: _____

Dependent Information – including yourself

Name: _____ Relationship: _____ Age: _____
 Name: _____ Relationship: _____ Age: _____

Guarantor Information:

Employer: _____ Phone Number: _____
Length of Employment: _____ Current Position: _____
Gross Salary: _____ Average Hours Worked per Week: _____

Spouse Information:

Employer: _____ Phone Number: _____
Length of Employment: _____ Current Position: _____
Gross Salary: _____ Average Hours Worked per Week: _____

Other Sources of Income:

Social Security: \$ _____ per _____
Pension: \$ _____ per _____
Railroad Retirement: \$ _____ per _____
Worker's Comp: \$ _____ per _____
Unemployment: \$ _____ per _____
Rental Property Income: \$ _____ per _____
Interest/Dividends: \$ _____ per _____
Tax Refund: \$ _____ per _____
Other: \$ _____ per _____

Total Household Gross Income in last 3 Months: \$ _____

Total Annual Household Gross Income: \$ _____

Please Note: PCMH/CliniCare cannot process your application for financial assistance without verifiable proof of household income.

I hereby request that Pembina County Memorial Hospital/CliniCare services be provided to me or my family members listed without charge or at a reduced charge as determined according to Federal Income Poverty Guidelines. In requesting this financial assistance, I believe that I am unable to pay for the health care services requested and all the information supplied by me in this application is complete and accurate. I understand that the information which I have submitted on this application is subject to verification. I do hereby release Pembina County Memorial Hospital / CliniCare and their respective agents and employees from all liability arising out of their reasonable efforts to verify information I have stated in this application.

****Signed: _____ Date: _____**

OFFICE USE ONLY

Date Application Received: _____ Date Applicant Notified: _____

Determination:

_____ Eligible for _____ % Financial Assistance Write off
_____ Denied: Incomplete Application. Signature Needed _____ Income Info Needed _____
_____ Denied: Verified Household Income over Federal Poverty Income Guidelines

Financial Assistance Write Off: _____ Balance Remaining: _____

Determination Made By: _____

Title: _____ Date: _____

Approved by: _____

Title: _____ Date: _____