

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.

- 1. Apply for medical assistance within the time frame required by the county social service office.
- 2. Attach a copy of the following:
 - a. Medical Assistance Determination from the county social service office
 - b. Most current federal income tax return
 - c. *Income verification* Paycheck stubs or bank statements from the last 3 months or copy of social security award letter
 - d. Listing of assets what you own.
 - e. Listing of liabilities what you owe monthly/quarterly/annual payments

Date Application Sent:			
	City	State	Zip
Hospital/Clinicare	•		-
Account:	Balance Due:		
	Balance Due:		
Depen	dent Information – including yo	ourself	
_	Relationship:		
	Relationship:		
	Relationship:	_	
	Relationship:	_	
	Relationship:		
	Relationship:		
Guarantor Information:			
Employer:	Phone Number:		
	Current Position:		
Gross Salary: Av	erage Hours Worked per Week: _		
Spouse Information:	1		
	Phone Number:		
	Current Position:		
	erage Hours Worked per Week:		

Other Sources of Income:

Social Securi	ity: \$	pe	er		
Pension:	\$	p	er		
Railroad Reti	rement: \$	p	er		
Worker's Cor	mp: \$	p	er		
Unemployme	ent: \$	p	er		
Interest/Divid	lends: \$	pe:	<u></u>		
Tax Refund:	\$	ne	r		
Other:	\$	pe	r		
		your applica	tion for fin	ancial assista	nce
am unable to pay ied by me in this h I have submitte County Memoria	for the health s application i ed on this app al Hospital / C	h care services complete blication is sollinicare and	ces requeste and accurat abject to ve their respo	ed and all the e. I understand erification. I de ective agents	nd that the lo hereby and
			Da	te:	
Y					
le for% F	lication . Signati	ure Needed _	Income I	nfo Needed	
d: Verified Househ	old Income over	r Federal Pov			
d: Verified Househ Write Off:			erty Income	Guidelines	
Write Off:		_ Balance Rei	erty Income	Guidelines	_
		_ Balance Rei	erty Income	Guidelines	_
Write Off:	Date:	_ Balance Rei	erty Income	Guidelines	
	Pension: Railroad Reti Worker's Cor Unemployme Rental Proper Interest/Divid Tax Refund: Other: Gross Income ousehold Gross IH/CliniCare ca proof of househ that Pembina Cor members listed were al Income Pove that Income Interest Income It is a begin in this in I have submitted County Memoria Ill liability arisin ication.	Pension: \$	Pension: \$	Pension: \$	MH/CliniCare cannot process your application for financial assistant proof of household income. That Pembina County Memorial Hospital/CliniCare services be promembers listed without charge or at a reduced charge as determined and Income Poverty Guidelines. In requesting this financial assistant unable to pay for the health care services requested and all the ied by me in this application is complete and accurate. I understant I have submitted on this application is subject to verification. I decounty Memorial Hospital / CliniCare and their respective agents all liability arising out of their reasonable efforts to verify informatication. Date: Date: Date Applicant Notified: