Pembina County Memorial Hospital
Wedgewood Manor

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. Attach a copy of the following:
   a. Most current federal income tax return
   b. ***Income verification***- Pay***c***heck stubs or bank statements from the last 3 months or copy of social security award letter

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: ____
Name: _____Relationship: _____ Age: ____
Name: _____Relationship: _____ Age: ____
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 represent 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: _____