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. 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: _____

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: _____
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: _____**

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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: _____