Dakota Regional Medical Center

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APPLICATION FOR UNCOMPENSATED CARE AND SERVICE

General Instructions:

You are applying for assistance to meet hospital costs. Your answers will largely determine whether you and/or the person for whom you are applying are eligible. You may ask other persons for help in completing the form if you wish. Application assistance is also available at no cost on-site at Patient Financial Services; Or by calling (701) 786-1700. An electronic version of the policy and application are also available at www.dakotaregional.com.

Your answers must be complete, clear, and correct. If they are not, the form will be returned to you for more information. Your answers must give a true and complete statement of facts. You could be asked to prove the accuracy of all your statements.

The following documents must be attached:

- Copy of recent Income Tax Return or 4506-T Request for Transcript for Tax Return
- Three months of most recent pay stubs (Three for each adult applying)
- Proof of application/denial for medical assistance including alternative financial aid

PERSONAL APPLICANT INFORMATION

Name: ____ Number of Children _________
First Middle Initial Last

Date of birth: ______________________ SSN: ______________ Phone: (____) _______- _________
Mo. Day Yr.

Mailing address: ________________________ ______________ ______ _________ _________
Street/Box City State Zip

If applicant has court appointed guardian what is the guardian's name and address?

__________________________________ ____
Name of Guardian Address of Guardian

MARITAL STATUS

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

If married or widowed, answer the following questions as they apply to your spouse:

Name: ____________________________ Address ____________________________ Birthdate _____________

Social Security No: __________ Medicare No. ____________ Railroad Retirement No. _____________

REASON FOR APPLYING FOR ASSISTANCE

I am applying for financial assistance because:

____
____
____

If over 65, blind or permanently disabled:

______________________	______________________	______________________
Name of Disabled Person	Date of Disability Determination	Name of Doctor

I, or a member of my family, received hospital/nursing home care for which payment has not yet been made.

Yes ☐ No ☐ If yes, please explain: ____

LIVING ARRANGEMENT

☐ Own Home	☐ Rented Apartment or Room	☐ Board and Room
☐ Rent Home	☐ In Home of Relative	☐ Nursing Home
☐ Foster Home	☐ State Hospital	☐ Other ______________

Cost by month of my living arrangement (Include only cost of rent, mortgage, or care) $ ____________________

I regularly pay for a housekeeper who helps me with my daily living ☐ Yes ☐ No

I have lived in the following places within the last 2 years (most recent first)

City (or county)	State	From (date)	To (Date)

ASSISTANCE /INSURANCE

I am currently receiving assistance from Social Services ☐ Yes ☐ No If yes, explain: ______________________
____
____

Medicare ☐ Yes ☐ No Number: ______________ Medicaid ☐ Yes ☐ No Number: ______________

Health Insurance ☐ Yes ☐ No Name of Insurance Company ______________ Policy No. ______________

INCOME

Study the kinds of income listed below and check each item "Yes" or "No". If you check a box marked "Yes, show the amount of money received, who receives it, and how often it is received (weekly, monthly, annually, ect.)

			To You	To Spouse	To dependent Children	How Often Received
Federal Social Security Benefits	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
ND social Security (OASIS)	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Railroad Retirement	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Veterans Benefits	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Civil Service Benefits	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Retirement (all sources)	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Payment from Boarder or Roomers	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Unemployment Benefits	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Workmen's Compensation	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Military Allotment or Retirement	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Contributions from Relatives	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Manpower Training Payments	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Neighborhood Youth Corps Payments	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Alimony or Child Support Payments	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Indian Lease Land Payments	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Rental or Land or Building	☐ Yes	☐ No	$ ______	$ ______	$ ______	______
Other Income (Explain	☐ Yes	☐ No	$ ______	$ ______	$ ______	______

I/We have applied for money(not including public assistance) which has not yet been received ☐ Yes ☐ No

If yes, what was applied for? ______________________________ Date applied ________________

EARNED INCOME

I, my spouse or dependent child(ren) are employed ☐ Yes ☐ No If yes, complete the following:

Name(s) of employed person(s) ______________________________

Name and address of employer(s) ______________________________ Years employed _______

Kind of work ______________________________ Number of hours worked each month ____________________

I/We are paid ☐ Hourly ☐ Weekly ☐ Every other week ☐ Twice a month ☐ Monthly

Other pay period (explain)______________________________

If less than 3 years, former employer ______________________________

	You	Spouse	Children
Total earnings from job per pay period (before deductions)	$ ___________	$ ___________	$ ___________
Deductions for: Withholding Tax	$ ___________	$ ___________	$ ___________
Social Security	$ ___________	$ ___________	$ ___________
Retirement Plan	$ ___________	$ ___________	$ ___________
Health Insurance	$ ___________	$ ___________	$ ___________
Other, If any	$ ___________	$ ___________	$ ___________
Total take-home pay (per pay period)	$ ___________	$ ___________	$ ___________

I pay for child care (baby sitting) while working ☐ Yes ☐ No

If yes, what amount is paid per month? __________________________ to whom paid? ________________________________

REAL PROPERTY (HOUSE(S) RENTAL PROPERTY AND LAND)

I/We own or are purchasing a home ☐ Yes ☐ No

If yes, give legal description (see tax statement) ______________________________

Assessed value $ __________________________ Balance owed: $ ________________________________

I/We own or are purchasing real property other than a home ☐ Yes ☐ No

If yes, give legal description (see tax statement) ______________________________

Assessed value $ __________________________ Balance owed: $ ________________________________

I/We own equity in Indian Trust Land ☐ Yes ☐ No

If yes, what is the location of land (include name of reservations(s)? ______________________________

PERSONAL PROPERTY

I/We own the following personal property (check each item "yes" or "No")

Item	Yes	Amount	No
Cash on Hand	☐ Yes	Amount $ _______________	☐ No
Checking account in bank	☐ Yes	Amount $ _______________	☐ No
Savings or certificate of deposit in bank, savings and loan association credit union, etc.	☐ Yes	Amount $ _______________	☐ No
U.S. Savings bond or other bonds, stocks, money markets, investments or retirement accounts	☐ Yes	Amount $ _______________	☐ No
Individual Indian Monies (IIM) Account	☐ Yes	Amount $ _______________	☐ No
Prepaid burial	☐ Yes	Amount $ _______________	☐ No

If yes, give name and address of funeral home: ______________________________

Car(s)	☐ Yes	☐ No	If yes, make and year ___________	Estimated value ________	Balance Owed ________
Truck	☐ Yes	☐ No	If yes, make and year ___________	Estimated value ________	Balance Owed ________
Livestock	☐ Yes	☐ No	If yes	Estimated value ________	Balance Owed ________
Machinery/tools	☐ Yes	☐ No	If yes	Estimated value ________	Balance Owed ________
Trailer Home	☐ Yes	☐ No	If yes	Estimated value ________	Balance Owed ________
Campers/Boats	☐ Yes	☐ No	If yes	Estimated value ________	Balance Owed ________
Snowmobile or Motorcycles	☐ Yes	☐ No	If yes	Estimated value ________	Balance Owed ________
Life Insurance	☐ Yes	☐ No	If yes, give total face value of all policies $ ____		

Name(s) and address(es) of company(ies) ___________________________ Policy Number(s) _____________________

Inheritance/settlement pending ☐ Yes ☐ No Estimated date ________________________

Other Personal Property ☐ Yes ☐ No; If yes describe ____

____Estimated value $ ______________

FINANCIAL ASSISTANCE RELEASE

I, (We) ____ have applied for The Financial Assistance program at the Dakota Regional Medical Center.

I, (We) hereby acknowledge that (I, we) do not carry any insurance coverage nor (am, I are, we) eligible for assistance from government programs.

I am, (We are) the responsible party for the charges under Account # ____

I, (We) hereby acknowledge that I (we) cannot pay for the self pay balances after our insurance has paid its portion of the charges.

Also, I, (we) give Dakota Regional Medical Center the approval to pull a credit report to review credit history. I (we) understand this is a requirement to be considered for the Financial Assistance program.

I certify that the information given by me on this form is correct and complete to the best of my knowledge.

Signature of applicant: ____ Date: __________________

Signature of spouse *(if spouse is living with you):* ____ Date: __________________

Name ____ Address ____
Signature and address of person, if any, who helped complete this form.

If applicant signed with a mark "x" or fingerprint, there must be two witnesses to mark or fingerprint:

Witness: ____ Witness: ____