Mountrail County Medical Center
P.O. Box 399
Stanley, ND 58784-0399
Phone: (701) 628-2424 Fax: (701) 628-3390

APPLICATION FOR PAYMENT REDUCTION/ FINANCIAL ASSISTANCE

Applicant's Name _____ Phone # _____

Date of Birth _____ Social Security #_____

Mailing Address: _____

City _____ State_____ Zip Code_____

Previous Address, if less than 3 years _____

Marital Status: _____ Married _____ Unmarried

Name & Address of nearest relative not living with you: _____

_____

Employment Status: ____ Retired ___ Full Time _____ Part Time _____ Unemployed

Employer Name _____ Address_____

Phone # _____ Title/Position _____

How long employed: _____ How often paid_____

Take home salary per month _____

Previous Employer Name and Address _____

_____

AMOUNT REQUESTED FOR PAYMENT REDUCTION/CHARITY CARE

HOSPITAL $_____ CLINIC $_____

AMOUNT YOU ESTIMATE YOU SHOULD BE ABLE TO PAY ON YOUR ACCOUNT:

HOSPITAL $_____ CLINIC $_____

Alimony, child support, or separate maintenance income need not be revealed if you do not wish to have it considered as a basis for repaying this obligation.

Alimony, child support, separate maintenance received under:
_____ Court Order _____ Written Agreement _____ Oral Understanding

JOINT APPLICANT OR OTHER PARTY INFORMATION

Name _____ Date of Birth _____

Employment Status _____Retired _____ Full Time _____ Part Time _____ Not Employed

Spouse's Employer _____ Address _____

Phone # (___)_____ Title/Position _____

How Often Paid _____ Take home salary per month _____

I am responsible for the support of the following:

Dependents	Age	Relationship

Health Insurance _____ Policy # _____

_____ Policy # _____

INFORMATION REQUIRED: COPIES OF YOUR MOST RECENT FEDERAL AND STATE INCOME TAX RETURNS AND PROOF OF THE LAST THREE MONTHS INCOME.

I authorize investigation of all matters contained in this payment reduction application and agree that if, in the judgment of Mountrail County Medical Center any misrepresentation or omission has been made by me or the results of such investigation are not satisfactory, this payment reduction application will be withdrawn immediately. I hereby release the designated hospital personnel and all parties who supply information at the request of the hospital personnel from liability for any acts of commission or omission, communications, or disclosures, which are made pursuant to such an investigation.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____

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Determination of Eligibility for Payment Reduction/Sliding Fee Scale

Income: a. Reported income for last 3 mo. $_____ X 4 = $_____
b. Reported income for last year $_____ Verified Yes:____ No:____
Means of verification (specific documentation):_____
_____
_____
(attach any pertinent documentation)

Total Requested: Clinic: $_____ Hospital: $_____

Eligibility: Clinic: No-pay: _____
Hospital: No-pay: _____

Ineligible: _____ Reason:_____
_____

Services: Have been delivered: _____ Date(s): _____
Will be delivered: _____ Date(s): _____

Comments: _____

_____

Date(s) Reviewed: _____

Reviewer Signature: _____

Administrative Approval: _____ _____
Signature Date

Date applicant was provided with determination: _____

1. To qualify for the Mountrail County Medical Center Financial Assistance Program, the following must be met:

a. A ratio is developed by dividing the individual's income by the Federal Poverty Guidelines.

2018 Poverty Guidelines for 48 Contiguous States and the District of Columbia

Persons in Family	Poverty Guideline	250% Of the Federal Poverty Guideline
1	**$12,140**	**$30,350**
2	**$16,460**	**$41,150**
3	**$20,780**	**$51,950**
4	**$25,100**	**$62,750**
5	**$29,420**	**$73,550**
6	**$33,740**	**$84,350**
7	**$38,060**	**$95,150**
8	**$42,380**	**$105,950**

a. The ratio is matched to the following chart, to determine amount eligible for financial assistance.

Ratio	Assistance Percentage
0% - 250%	**100%**
251%-Over	**0%**