Mountrail County Medical Center
P.O. Box 399
Stanley, ND 58784-0399
Phone: (701) 628-2424 Fax: (701) 628-2231

APPLICATION FOR PAYMENT REDUCTION/ SLIDING FEE

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

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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 # ___________________________

<u>INFORMATION REQUIRED:</u> 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 ________________________