St. Aloisius Medical Center
SMP Health System
325 Brewster Street East
Harvey, ND 58341
Phone: 701-324-4651
Fax: 701-324-4687

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. Applications for assistance are also available at no cost on-site in the Business Office or calling (701) 324-5104. An electronic version of the policy and application are also available at www.staloisius.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 Verification of non-filing
- Three months of most recent pay stubs (three for each adult applying)
- Proof of application/denial for medical assistance including alternative financial aid

Personal Information About Applicant(s)

Name_____ Birthdate _____ # Dependent Children _____
First Middle Initial Last Mo. Day Yr.

Mailing Address_____
Street/Box City State Zip

Social Security No._____ ( ) _____
Area Code Phone Number

If applicant has court appointed guardian what is 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. _____

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 care for which payment has not yet been made.

____ Yes ____ No If yes, explain_____

_____

Living Arrangement

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

Describe_____

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

If yes, name of housekeeper_____ Cost per month $ _____

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 the Social Services ____ Yes ____ No If yes, explain:_____

_____

_____

Medicare ❑ Yes ❑ No Number _____ Medicaid ❑ Yes ❑ No Number _____

Health Insurance ❑ Yes ❑ No 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, etc.)

	To You	To Spouse	To Dependent Children	How Often Received
Federal Social Security Benefits. . . . ❑ Yes ❑ No	$_____	$_____	$_____	_____
North Dakota Social Security (OASIS) ❑ Yes ❑ No	$_____	$_____	$_____	_____
Railroad Retirement. . . . . ❑ Yes ❑ No	$_____	$_____	$_____	_____
Veterans Benefits . . . . . ❑ Yes ❑ No	$_____	$_____	$_____	_____
Civil Service Benefits. . . . . ❑ Yes ❑ No	$_____	$_____	$_____	_____
Retirement (all sources) . . . . . ❑ Yes ❑ No	$_____	$_____	$_____	_____
Payments from Boarders 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 of 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) _____ yrs employed _____
Kind of work_____ Number of hours worked each pay period _____
I/We are paid ❑ Hourly; ❑Weekly; ❑ Every other week; ❑ Twice a month; ❑ Monthly
Other pay period (explain)_____

	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 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 or have equity in Indian Trust Land ❑ Yes ❑ No
If yes, what is the location of land (include name of reservation(s))?_____

Personal Property

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

Cash on hand . . . . . ❑ Yes; Amount $ _____ ❑ No
Checking account in bank. . . . . ❑ Yes; Amount $ _____ ❑ No
Health Savings Account . . . . . ❑ Yes; Amount $ _____ ❑ No
Savings or certificates 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_____
Vehicle(s) ❑ Yes ❑ No; If yes, Make and year_____ Estimated value $_____ Balance owed $_____
Make and year_____ Estimated value $_____ Balance owed $_____
Make and year_____ Estimated value $_____ Balance owed $_____
Livestock ❑ Yes ❑ No; If yes, estimated value $ _____ Balance owed $ _____
Trucks/Machinery and/or tools ❑ Yes ❑ No; If yes, estimated value $ _____ Balance owed $ _____
Trailer home ❑ Yes ❑ No; If yes, estimated value $ _____ Balance owed $ _____
Campers or 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; Est. date _____
Other personal property ❑ Yes ❑ No; If yes, describe_____

_____ Estimated value $ _____

Financial Assistance Release

{I, We}, _____, have applied for the Financial Assistance program at St. Aloisius Medical Center.

{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 St. Aloisius Medical Center the approval to pull a credit report to review credit history.

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

_____ Date _____
Signature (or mark) of applicant (or legal guardian)

_____ Date _____
Signature (or mark) of spouse if living with you

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 _____

As a reminder, the following documents must be attached:

- Copy of recent Income Tax Return or 4506-T Request for Verification of non-filing (can be found online or by request from billing office)
- Three months of most recent pay stubs (three for each adult applying)
- Proof of application/denial for medical assistance including alternative financial aid (Applying for Medicaid)