Heart of America Medical Center
800 South Main Avenue
Rugby, ND 58368

Date of Request: _____

Instructions: Complete application and attach copies of at least one of the following:

- Tax return and supporting schedules (previous years)
- Bank Statements (most recent 3 months for all accounts)
- Pay Stubs (most recent 3 months)
- Social Security/Disability benefits

I, _____ hereby request that Heart of America Medical Center (HAMC) make a determination of my eligibility for community care program services at HAMC. I understand that the information which I submit will be subject to verification by HAMC, and if the information which I submit is determined to be false, it will result in a denial of caring program services.
Services not eligible for the community care program include, but are not limited to: non-medically necessary services, cosmetic services and long term care.

1. Name: _____
First Middle Last

Physical Address: _____
Number and Street City State Zip Code

Mailing Address:_____
Number and Street City State Zip Code

Social Security # _____ Date of Birth: _____

Marital Status: Single Married Widow Divorced

Telephone: _____ Cell Phone: _____

If student: School_____ Full time _____ Part time _____

Occupation: _____ Date of unemployment, if applicable: _____

Employer: _____ Phone: _____

Employer Mailing Address: _____
Number and Street City State Zip Code

2. Spouse Name: _____
First Middle Last

Social Security # _____ Date of Birth: _____

Telephone: _____ __ Cell Phone: _____

If student: School_____ Full time _____ Part time _____

Occupation: _____ Date of unemployment, if applicable: _____

Employer: _____ Phone: _____

Employer Mailing Address: _____
Number and Street City State Zip Code

To be completed - facility personnel only
This document was received on by

3. **Dependents:** *Household dependents that are claimed on tax return.*
Dependents over 18 must show proof of disability and/or verification of income if providing towards support of household.

Name	Relationship	Date of Birth

4. **Income:** A) List total gross income for household below for the last 12 months;
B) You must provide a copy of your most recent Federal Income Tax Return (or complete a Form 4506-T to verify that you did not file Federal income Tax); or
C) You must provide us with verification of income for the last 3 months.

Self		**Spouse**	
Wage Income		Wage Income	
Farm or Self-Employment		Farm or Self-Employment	
Social Services (Food Stamps, AFDC, WIF, etc.)		Social Services (Food Stamps, AFDC, WIF, etc.)	
Social Security/Disability		Social Security/Disability	
Unemployment compensation		Unemployment compensation	
Worker's Compensation		Worker's Compensation	
Strike Benefits		Strike Benefits	
Alimony/Child Support		Alimony/Child Support	
Military Family Allotments		Military Family Allotments	
Pension		Pension	
Income from Dividends/Interest		Income from Dividends/Interest	
Rental Property		Rental Property	
Inheritance		Inheritance	
Stocks/Bonds		Stocks/Bonds	
Other		Other	
Sub Total:		**Sub Total:**	

TOTAL: _____

5. Health Insurance: Do you have any type of health insurance such as Blue Cross, Medicare, Medicaid, or commercial insurance? Yes No If yes, please specify below:

Insurance Name: _____ Policy # _____ Group # _____

Insurance Name: _____ Policy # _____ Group # _____

In order to make a determination on your application, please provide me with the following:

_____

Return requested documentation by: _____

I affirm that the information listed in this Request is true and correct to the best of my knowledge. I hereby authorize HAMC to investigate any information provided and I authorize the release of any information that HAMC deems necessary in making an eligibility determination.

Signature (person making request) Date