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

		Date of R	equest:	
·	cation and attach copies of rting schedules (previous y st recent 3 months for all a	vears) • I	following: Pay Stubs (most rece Social Security/Disab	•
I		harahy raquast tha	t Heart of America N	Medical Center
I,(HAMC) make a determinatio information which I submit w determined to be false, it will Services not eligible for the c services, cosmetic services an	n of my eligibility for comr ill be subject to verification result in a denial of caring ommunity care program i	munity care program son by HAMC, and if the program services.	services at HAMC. I information which	understand that the I submit is
1. Name:				
First	Middle	Last		
Physical				
Address:			7:n Codo	
Number and Str Mailing Address:	eet City	State	Zip Code	
Number and Str	eet City	State	Zip Code	
Social Security #		Date of Birth:		
		Date of Birtin		
Marital Status: Single M	arried Widow D	ivorced		
Telephone:	Cell Pl	hone:		
If student: School		Full time	Part time	
Occupation:	Date of u	nemployment, if appl	icable:	
Employer:	Phone:			
Employer Mailing Address: _				
	Number and Street		State Zip C	ode
2. Snousa Namo:				
2. Spouse Name: First	Middle		Last	
Social Security #	Date	e of Birth:		
Telephone:				
If student: School				
Occupation:	Date of unemp	oloyment, if applicable	e:	
Employer:		Phone:		
Employer Mailing Address:				
	Number and Street		State Zip C	ode
	To be completed	I - facility personnel on	ly	

by

This document was received on

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 Incomo	A) List total gross income for h	sousabald balow for the	last 12 months.	
4. Income:	A) List total gross income for h		al Income Tax Return (or complete a	
	Form 4506-T to verify that you		·	
	C) You must provide us with v		•	
Self		<u>Spouse</u>		
Wage Income		Wage Income		
Farm or Self-Employ	vment	Farm or Self-Emp	olovment	
Social Services	(Food	Social Services	(Food	
Stamps, AFDC, WIF, etc.	•	Stamps, AFDC, WIF,	•	
Social Security/Disa	bility	Social Security/D	Disability	
Unemployment con	npensation	Unemployment	compensation	
Worker's Compensa	ation	Worker's Compe	ensation	
Strike Benefits		Strike Benefits		
Alimony/Child Supp	ort	Alimony/Child Su		
Military Family Allo	tments	Military Family A	Allotments	
Pension		Pension		
Income from Divide	nds/Interest	Income from Div	ridends/Interest	
Rental Property		Rental Property		
Inheritance		Inheritance		
Stocks/Bonds		Stocks/Bonds		
Other		Other		
Sub Total:		Sub Total:		
	IOIAL:			
5 Health Insurance	Do you have any type of health	insurance such as Rlue C	ross, Medicare, Medicaid, or commercial	
	No If yes, please specify below		1033, Wicalcare, Wicalcara, or commercial	
Insurance Name:	Policy #	Group #		
	Policy #			

Dependents: Household dependents that are claimed on tax return.

3.

Return requested documentation by:				
	is true and correct to the best of my knowledge. I hereby authorize d I authorize the release of any information that HAMC deems			
Signature (person making request)	Date			

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