South Central Health

Return all applications to:

South Central Health
1007 4th Ave S
PO Box 647
Wishek, ND 58495
701-452-2326 or 1-800-492-2364

Uncompensated Care (Financial Assistance) Application

South Central Health (SCH) is dedicated to providing health care to our patients, regardless of their ability to pay for these services. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance. Discounts are offered based on family size and annual income.

This form will need to be submitted as soon as possible. Please make every effort to return your application within two weeks of receiving. This form must be completed every 6 months or if your financial situation changes.

In order to process this application we require:

- The enclosed application completed in its entirety.
- Copy of your last three months income for all wage earners contributing to your household income or a copy of your most recent income tax return.
- Also income verification is needed if receiving income from another source, such as Social Security, Unemployment Benefits, Retirement, Alimony, Child Support, VA or Welfare.
- Necessary signature on the last page.

PART 1: Demographic Information

Guarantor Name _____ Birthdate _____

Spouse Name _____ Birthdate _____

Mailing Address _____
Street/Box City State Zip

Guarantor Employment _____ Job Title _____

Spouse Employment _____ Job Title _____

List **ALL** dependents living in your household:

_____ _____

_____ _____

_____ _____

_____ _____

PART 2: Monthly Source of Income – Represents all sources before taxes

	Self Monthly Gross	Spouse Monthly Gross
Gross Income	$ _____	$ _____
Social Security/SSI	$ _____	$ _____
Public Assistance	$ _____	$ _____
Rental income	$ _____	$ _____
Retirement/Pension	$ _____	$ _____
Veterans Benefits	$ _____	$ _____
Unemployment/Work Comp	$ _____	$ _____
Child Support/Alimony	$ _____	$ _____
Other (specify)	$ _____	$ _____
TOTAL	**$** _____	**TOTAL** **$** _____

COMBINED MONTHLY GROSS INCOME: $ _____

PART 3: Income Taxes

☐ I have not filed for income taxes in the past year due to a low–income status. _____ *Initial*

☐ I am up-to-date on filing for income taxes and have enclosed latest return.

PART 4: Additional comments

_____

_____

_____

_____

_____

Assignment of Rights (Please read carefully)

By signing below I certify that the information contained in this Uncompensated Care Application for financial assistance and the documentation which I have submitted are accurate, true and correct to the best of my knowledge.

I understand that SCH may make reasonable requests for additional information and verification if necessary.

I understand that the information and documentation provided will be kept confidential by SCH.

I understand that the completion of this application will allow SCH to consider my circumstances.

I understand SCH makes no representations that financial assistance is guaranteed.

I/We hereby certify the above information is correct and voluntarily authorize you to obtain credit information relative to me/us.

Guarantor/Applicant's Signature _____ **Date:** _____

Co-Applicant Signature _____ **Date:** _____