SMP Health
St. Aloisius

325 Brewster Street East
Harvey, ND 58341

Phone: 701-324-4651
Fax: 701-324-4687

CARING PROGRAM APPLICATION

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. _____ ( ) _____
Area Code Phone Number

Dependents

Name of Child(ren) and DOB _____

_____

_____

Do any of the applicants listed above have any type of health insurance such as BCBS, Medicare, Medicaid, or any other commercial insurance? ❑ Yes ❑ No

If yes, please specify below:

Insurance Name: _____ Policy #: _____
Insurance Name: _____ Policy #: _____
Insurance Name: _____ Policy #: _____
Insurance Name: _____ Policy #: _____
Insurance Name: _____ Policy #: _____

Financial Information

Following documentation is required

❑ Proof of denial from Medicaid and/or Medicaid Expansion
❑ Photocopy of your two current paycheck vouchers and/or paystub
❑ Photocopy of your statement of unemployment benefits
❑ If you have Social Security, a copy of your latest benefit statement or SSA-1099
❑ Copy of latest Federal Income Tax Return
❑ If you have not filed, complete the **4506T-EZ** form to verify that you did not file Federal Income Taxes
❑ Is anyone in your household employed? ❑ Yes ❑ No
❑ List total income for each person living in your residence over the age of 18.

List employers:

_____ _____
_____ _____

Monthly Income

		Self	Spouse-(co-habitant)
Wage Income.	❑ Yes ❑ No	$_____	$_____
Social Security Benefits.	❑ Yes ❑ No	$_____	$_____
Social Services (Food Stamps, AFDC, etc.) .	❑ Yes ❑ No	$_____	$_____
Retirement (all sources)	❑ Yes ❑ No	$_____	$_____
Unemployment Benefits	❑ Yes ❑ No	$_____	$_____
Workmen's Compensation	❑ Yes ❑ No	$_____	$_____
Military Allotment or Retirement	❑ Yes ❑ No	$_____	$_____
Alimony or Child Support Payments. . .	❑ Yes ❑ No	$_____	$_____
Rental Income.	❑ Yes ❑ No	$_____	$_____
Other Income (Explain).	❑ Yes ❑ No	$_____	$_____
Sub Total:		**$**_____	**$**_____

TOTAL: $_____

Financial Assistance Release

I certify that the information provided is true and correct to the best of my knowledge and belief. I also authorize St. Aloisius Medical Center to investigate the financial information provided. I also authorize the release of any information that is deemed necessary in making an eligibility determination. I understand that any false representation or misinformation can invalidate any discounts allowed by St. Aloisius Medical Center.

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

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

FACILITY PERSONNEL ONLY

This document was received on _____ by _____.