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 #: _________________________
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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 SMP Health- St. Aloisius 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 SMP Health - St. Aloisius.

____ 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 ____________________________.