

SMP Health – St. Andrew’s
316 Ohmer Street Bottineau, ND 58318
Caring Program Application

Person Responsible/Guarantor for Account

Name _____
DOB: _____
Home Ph: _____ Cell: _____
Street _____
City, St., Zip _____

Significant Other _____
DOB: _____
Home Ph: _____ Cell: _____
No. of Children claimed on tax return _____

Name of Children and DOB _____

Do any if the applicants Listed above have any type of health insurance such as Blue Cross, 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 # _____

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:

_____	_____
_____	_____
_____	_____

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Monthly Income

Self

Wage income _____
 Social Services
 (Food Stamps, AFDC, etc.) _____
 Social Security _____
 Unemployment Compensation _____
 Worker’s Compensation _____
 Alimony _____
 Child Support _____
 Military Family Allotments _____
 Pension/Retirement _____
 Rental Income _____
 Other _____

Sub Total: _____

Spouse-(Co-habitant)

Wage income _____
 Social Services
 (Food Stamps, AFDC, etc.) _____
 Social Security _____
 Unemployment Compensation _____
 Worker’s Compensation _____
 Alimony _____
 Child Support _____
 Military Family Allotments _____
 Pension/Retirement _____
 Rental Income _____
 Other _____

Sub Total: _____

TOTAL: _____

I certify that the information provided is true and correct to the best of my knowledge and belief. I also authorize SMP Health - St. Andrew’s to investigate 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. Andrew’s.

 Name

 Date

DO NOT COMPLETE – FACILITY PERSONNEL ONLY

This document was received on _____ by _____.