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 last two month's paycheck vouchers and/or paystubs
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		Spouse-(Co-habitant)	
Wage income	_____	Wage income	_____
Social Services (Food Stamps, AFDC, etc.)	_____	Social Services (Food Stamps, AFDC, etc.)	_____
Social Security	_____	Social Security	_____
Unemployment Compensation	_____	Unemployment Compensation	_____
Worker's Compensation	_____	Worker's Compensation	_____
Alimony	_____	Alimony	_____
Child Support	_____	Child Support	_____
Military Family Allotments	_____	Military Family Allotments	_____
Pension/Retirement	_____	Pension/Retirement	_____
Rental Income	_____	Rental Income	_____
Other	_____	Other	_____
Sub Total:	**_____**	**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_____.