

Hospital: 909 2nd Street
Langdon, ND 58249
701-256-6127
Fax: 701-256-2170 - office
julief@ccmhnd.com

Clinic: 901 2nd Street
Langdon, ND 58249
701-256-6120
Fax: 701-256-6156

Clinic: 301 5th Street
Walhalla, ND 58282
701-549-2711
Fax: 701-549-2710



www.cavaliercountyhospital.com

Application for Charity Care

Cavalier County Memorial Hospital's Charity Care policy requires that an individual must complete the following prior to a Charity application being processed.

1. Could you possibly qualify for Medicaid? (Coverage is available to all qualifying low income adults under age 65) ____ Yes ____ No

If you answered Yes to #1, complete steps #2 and #3.
If you answered No to #1, skip to step #3.

2. Apply for medical assistance (Medicaid) within the time frame (generally 3 months within the date of service) required by the county office.

3. Attach a copy of the following **(REQUIRED)**:
- a. Medical Assistance Determination
 - b. Healthy Steps Determination (if applicable)
 - c. Most current Federal Income Tax return
 - d. Check stubs or bank statements from the last 3 months of income

Date application sent to CCMH: _____

Guarantor's Name: _____

Address: _____
Mailing address City State Zip

Account # _____ Balance Due _____

Account # _____ Balance Due _____

Dependent Information: (as claimed on the Federal Tax return)

Name: _____ Relationship: _____ Age: _____
Name: _____ Relationship: _____ Age: _____
Name: _____ Relationship: _____ Age: _____
Name: _____ Relationship: _____ Age: _____
Name: _____ Relationship: _____ Age: _____

Guarantor Information:

Employer: _____ Telephone Number: _____
Length of Employment: _____
Current Position: _____
Gross Salary: _____
Average Number of Hours Worked per Week: _____

Spouse Information:

Employer: _____ Telephone Number: _____
Length of Employment: _____
Current Position: _____
Gross Salary: _____

Average Number of Hours Worked per Week: _____

Other Sources of Income: (include spouse's other income)

Social Security \$ _____ per _____

Pension \$ _____ per _____

Railroad Retirement \$ _____ per _____

Workers Compensation \$ _____ per _____

Unemployment \$ _____ per _____

Rental Property Income \$ _____ per _____

Child Support/Alimony \$ _____ per _____

Interest/Dividends \$ _____ per _____

Tax Refund \$ _____ per _____

Other \$ _____ per _____

Total Annual Household Gross Income: \$ _____

Total Household Gross Income in last 3 months: \$ _____

Please note: CCMH cannot process your application without verifiable proof of household income.

Questions? Please call our Business Office at 256-6100 or our CFO at 256-6177.

I hereby request Cavalier County Memorial Hospital that services be provided to me or my family member without charge or at a reduced charge as determined according to Federal Income Poverty Guidelines. In requesting this charity care, I represent that I am unable to pay for the health care services requested or provided and all the information supplied by me in this application is complete and accurate. I understand that the information which I have submitted on this application is subject to verification. I do hereby release Cavalier County Memorial Hospital and their respective agents and employees from all liability arising out of their reasonable efforts to verify information I have stated in this application.

I understand that if I do not make payments on my account and it goes into collections, any discount I received from Charity Care will be reversed and the full balance prior to Charity Care will be collected by the collection agency.

Signed: _____ Date: _____

Office Use Only

Control Number: _____

Date Application Received: _____

Determination:

_____ Eligible for _____ % Write Off to Charity

_____ Denied: Incomplete Application

_____ Denied: Verified Household Income over Federal Income Guidelines

Charity Care Write Off: _____ Balance Remaining: _____

Determination Made by: _____

Title: _____ Date: _____