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

CAVALIER COUNTY MEMORIAL HOSPITAL & CLINICS

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.

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: _____

Approved by: _____
Title: _____ Date: _____
Date Applicant Notified: _____