400 East First Street ● Morris, MN 56267 ● 320-589-1313 ● *www.scmcinc.org*

STEVENS COMMUNITY CARE APPLICATION

PATIENT / RESPONSIBLE PARTY INFORMATION

Name_______________________________________

Address______________________________________

City/State/Zip__________________________________

Phone_______________________________________

DOB______________

Spouse's Name________________________________

DOB______________

CURRENT MEDICAL INSURANCE

Insurance Company ___________________________

Policy # _______________ Effective Date _________

Medicare # ____________ Effective Date: ________

Medicaid # ____________ Effective Date _________

Are you a Minnesota Senior Federation member? ____

DEPENDENTS Use an additional sheet if necessary

Name(s)	Date(s) of Birth	Relationship
____________________	______________	______________
____________________	______________	______________
____________________	______________	______________
____________________	______________	______________

MONTHLY INCOME (Gross Income**)**

Patient $____________________

Spouse $____________________

Interest/Dividends $____________________

Child support/Other $____________________

TOTAL $____________________

EMPLOYMENT INFORMATION

Patient: Employed Self-Employed Unemployed Retired

Spouse: Employed Self-employed Unemployed Retired

This information is true and correct to the best of my knowledge, and I authorize SCMC to process my application. I agree to notify SCMC of changes to my insurance coverage, employment, dependent or other income information. SCMC reserves the right to ask customers to re-apply. If I have applied for MNSure or other Medical Assistance programs I authorize SCMC to discuss my information with those affiliates as needed to coordinate my potential insurance coverage.

Date _________________ Applicant's signature ____

Date _________________ Spouse's signature ____

Date _________________ SCMC Administrative Approval _____________________________________

Eligible ____________ Non-Eligible _________________

Routing: Given to patient to fill out →
Patient Account Services retains for 1 year → scan → shred

bo2 (1-06) rev 5-18