STEVENS COMMUNITY MEDICAL CENTER

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

STEVENS COMMUNITY CARE APPLICATION

Stevens Community Medical Center (SCMC) is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship. Therefore, we are offering you the opportunity to apply for financial assistance through SCMC.

Attached you will find the application that will help us assess your financial situation. You must complete the application to receive any consideration for SCMC financial assistance program. If your financial situation meets SCMC guidelines, part or all of your account balance may be forgiven. A determination for SCMC Community Care eligibility will be made within 30 days of receiving a completed application including supporting documents. A letter will be sent to you with the results or to request additional documentation. If you qualify for a percentage discount, you will be responsible for the remainder of the balance and consistent monthly payments need to be made in order to prevent further collections efforts.

In order to process your application, we require:

1. **The enclosed application completed in its entirety**
2. **Copy of last <u>two</u> pay stubs for any wage earner contributing to household income**
3. **Copy of your most recent 1040 tax return or Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)**
4. **Social Security Awards letter**
5. **Please provide a copy of all health insurance information**

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation. Expense forms are routinely included to further reflect your circumstances.

Once we have reviewed your application, we will notify you of our decision in writing within 30 days of receipt. If you wish to discuss your account or if you have any questions, please contact Lisa (SCMC Financial Counselor) at 320-208-7832 or the Patient Account Services at 320-589-7667. Stevens Community Medical Center Patient Account Services hours are Monday - Friday 7:30-4:30.

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PATIENT / RESPONSIBLE PARTY INFORMATION

Name_____

Address_____

City/State/Zip_____

Phone_____

DOB_____

Other Household Income Earner - Name: _____

Are you a Minnesota Senior Federation member? ____

DOB_____

CURRENT MEDICAL INSURANCE

Insurance Company _____

Policy # _____ Effective Date _____

Medicare # _____ Effective Date: _____

Medicaid # _____ Effective Date _____

DEPENDENTS Use an additional sheet if necessary

Name(s)	Date(s) of Birth
_____	_____
_____	_____
_____	_____
_____	_____

MONTHLY INCOME (Gross Income)

Patient $_____

Other Household Income Earner $_____

Interest/Dividends $_____

Child support/Other $_____

TOTAL $_____

EMPLOYMENT INFORMATION

Patient: Employed Self-Employed Unemployed Retired

Other Household Income Earner: 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 _____ Other Household Income Earner signature _____

Date _____ SCMC Administrative Approval _____

Eligible _____ Non-Eligible _____

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

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STEVENS COMMUNITY CARE EXPENSE REPORT

The information disclosed below will only be used to determine your ability to make monthly payments on your account. It is not a pre-requisite to receiving health care nor will it be disclosed to other creditors or anyone requesting financial data.

Name:_____

Other Household Income Earner:_____

Address:_____

Telephone Number: (H) _____ (W)_____ Family Size_____

Your Employer: _____ Avg. Hours Per Week _____

Other Household Income Earner Employer: _____ Avg. Hours Per Week _____

MO Gross Income: Yours: _____

Other Household Income Earner: _____ Other: _____ Total: $ _____

Monthly Expenses:

Rent/Mortgage PMNT	$	Sewer, Water, Garbage	$
Home Taxes/Insur	$	Gasoline	$
Electricity	$	Daycare	$
Heat	$	Groceries	$
Insurance, Car	$	Telephone	$
Insurance, Health	$		
Insurance, Life	$	Balance Owing:	
Bank Loans	$		$
Bank Loans	$		$
Charge Account: _____	$		$
Charge Account: _____	$		$
Charge Account: _____	$		$
Stevens Community Medical Center	$		$
Medical: _____	$		$
Medical: _____	$		$
Medical: _____	$		$
Other: _____	$		$
Other: _____	$		$

Total Gross Income: $ _____ Total Expenses: $ _____ Difference: $_____

I verify that the above is true and correct to the best of my knowledge.

Applicant signature: _____

TO BE COMPLETED BY STEVENS COMMUNITY MEDICAL CENTER PATIENT ACCOUNT SERVICES.

Recommendations: _____

Completed by: _____ Date: _____

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