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 two 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 an additional optional way for patients to provide more information about their current 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 used to evaluate eligibility for financial assistance. This information will not be disclosed to other creditors or anyone requesting financial data.
NOTE: *This form is not required of any applicant found to be at or below 200% of Federal Poverty Guidelines.*

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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