

**NELSON COUNTY HEALTH SYSTEM
CHARITY CARE APPLICATION
ELIGIBILITY DETERMINATION FORM**

Date of Request _____ Patient's Name: _____

Responsible Party's Name: _____ Spouse's Name _____

Address: _____ Phone: _____

_____ Other Phone #: _____

Charity Care Requested by: _____

Number of persons in the family: _____ Family income last 12 months: _____
(verification through last year's tax return or other official verification as noted on guidelines)

Family income projected next 12 months: _____

Please list all employers for the past year, including their phone number address, and your job duties:
(Include listings for your spouse as well, if applicable - may continue on back side of form).

Employer:	Phone:	Address:	Your Duties:
1. _____			
2. _____			
3. _____			
4. _____			

I am seeking Charity Care for services that have Already been provided Not yet provided

Further Explanation:

(If additional space is required, please continue on the back side of this form.)

I understand that the information which I submit is subject to verification by NCHS and subject to review and determination by applicable personnel at NCHS. I certify that the information I have provided as well as the information I have noted above, is accurate, true, and correct.

Signature of Requestor

CHARITY CARE GUIDELINES

Charity Care will be available to those whose family incomes do not exceed 200% of the current poverty income guidelines established by the Department of Health and Human Services.

If you do not fall within the income guidelines, but feel you are having a hardship at this time, you may complete all application with a Financial Statement and indicate why you are applying for this service at this time.

All amounts charged to patients will be standard charges, which will be adjusted according to a patient's household size and income. The attached federal poverty guidelines will be used to assess the percentage a patient will be responsible for paying. The guidelines will be updated annually to reflect changes in the national guidelines.

All applications for Charity Care must be updated annually. The discount will be applied to private pay patient's responsibility/co-pay amounts.

Acceptable forms of verification that will be utilized to determine your eligibility and responsibility include:

- (1) Current state and federal tax documents
- (2) Two or more current paycheck stubs
- (3) Social Security Benefit Letter (Available through the local Social Security office)
- (4) Unemployment Benefit Letter (Available at Job Services)
- (5) Other documentation verifying the applicant's gross incomes
- (6) Letter denying unemployment benefits

Acceptable forms of verification of NO income include:

- (1) College students must include their college ID, class schedule, and a financial aid letter.
- (2) Brief letter from an individual familiar with the applicant's circumstances. The letter must include the signature, valid telephone number and the address of the individual that we will be able to use to contact the letter writer.
- (3) Termination notice or letter from applicant's former employer stating when his/her employment ended. The notice/letter must include the signature, valid telephone number and the address of the individual.
- (4) Copy of applicant's monthly bank statement, if he/she is living on savings.
- (5) Other documentation indicating the applicant does not have household income.

Denials for assistance from the North Dakota Medical Assistance, Health Steps, and the Caring Program for children should be included in the documentation, if applicable.

After completion of the Charity Care Application, and verification forms noted above, the NCHS Business Office will review and verify all documentation received. The applicant will be notified of the verification and determination of the percentage the patient is responsible for paying. If needed, a payment plan can be set up at that time.

If you have any questions, please contact the NCHS Business Office @ 701-322-4328.

**Nelson County Health System
2018 Income Guidelines
Charity Care Program
Sliding Fee Schedule**

Maximum Annual Income Amounts for Each Sliding Fee Percentage Category (except for 0% discount)												
Poverty Level*	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	Above 200%
Family Size	CHARGE											
	Nominal Fee \$10	Nominal Fee \$10	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
1 person	\$12,140	\$13,354	\$14,568	\$15,782	\$16,996	\$18,210	\$19,424	\$20,638	\$21,852	\$23,066	\$24,280	\$24,281
2 persons	\$16,460	\$18,106	\$19,752	\$21,398	\$23,044	\$24,690	\$26,336	\$27,982	\$29,628	\$31,274	\$32,920	\$32,921
3 persons	\$20,780	\$22,858	\$24,936	\$27,014	\$29,092	\$31,170	\$33,248	\$35,326	\$37,404	\$39,482	\$41,560	\$41,561
4 persons	\$25,100	\$27,610	\$30,120	\$32,630	\$35,140	\$37,650	\$40,160	\$42,670	\$45,180	\$47,690	\$50,200	\$50,201
5 persons	\$29,420	\$32,362	\$35,304	\$38,246	\$41,188	\$44,130	\$47,072	\$50,014	\$52,956	\$55,898	\$58,840	\$58,841
6 persons	\$33,740	\$37,114	\$40,488	\$43,862	\$47,236	\$50,610	\$53,984	\$57,358	\$60,732	\$64,106	\$67,480	\$67,481
7 persons	\$38,060	\$41,866	\$45,672	\$49,478	\$53,284	\$57,090	\$60,896	\$64,702	\$68,508	\$72,314	\$76,120	\$76,121
8 persons	\$42,380	\$46,618	\$50,856	\$55,094	\$59,332	\$63,570	\$67,808	\$72,046	\$76,284	\$80,522	\$84,760	\$84,761
For each additional person, add	\$4,320	\$4,752	\$5,184	\$5,616	\$6,048	\$6,480	\$6,912	\$7,344	\$7,776	\$8,208	\$8,640	\$8,640

*Based upon 2018 Federal Poverty Guidelines