

**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) Family Size
- (2) Income

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**  
**2025 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%	
	CHARGE												
Family Size	Nominal Fee \$10	Nominal Fee \$10	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
1 person	\$15,650	\$17,215	\$18,780	\$20,345	\$21,910	\$23,475	\$25,040	\$26,605	\$28,170	\$29,735	\$31,300	\$31,301	
2 persons	\$21,120	\$23,232	\$25,344	\$27,456	\$29,568	\$31,680	\$33,792	\$35,904	\$38,016	\$40,128	\$42,240	\$42,241	
3 persons	\$26,650	\$29,315	\$31,980	\$34,645	\$37,310	\$39,975	\$42,640	\$45,305	\$47,970	\$50,635	\$53,300	\$53,301	
4 persons	\$32,150	\$35,365	\$38,580	\$41,795	\$45,010	\$48,225	\$51,440	\$54,655	\$57,870	\$61,085	\$64,300	\$64,301	
5 persons	\$37,650	\$41,415	\$45,180	\$48,945	\$52,710	\$56,475	\$60,240	\$64,005	\$67,770	\$71,535	\$75,300	\$75,301	
6 persons	\$43,150	\$47,465	\$51,780	\$56,095	\$60,410	\$64,725	\$69,040	\$73,355	\$77,670	\$81,985	\$86,300	\$86,301	
7 persons	\$48,650	\$53,515	\$58,380	\$63,245	\$68,110	\$72,975	\$77,840	\$82,705	\$87,570	\$92,435	\$97,300	\$97,301	
8 persons	\$54,150	\$59,565	\$64,980	\$70,395	\$75,810	\$81,225	\$86,640	\$92,055	\$97,470	\$102,885	\$108,300	\$108,301	
For each additional person, add	\$5,500	\$6,050	\$6,600	\$7,150	\$7,700	\$8,250	\$8,800	\$9,350	\$9,900	\$10,450	\$11,000	\$11,000	

\*Based upon 2025 Federal Poverty Guidelines