**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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(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.

AII 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
Ietter.

 (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/Ietter 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 Charily 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.

