

St. Andrew's Health Center/St. Andrew's Bottineau Clinic
316 Ohmer Street • Bottineau, ND 58318
Caring Program Application

Date of Request: _____

I _____ hereby request that St. Andrew's Health Center (SAHC) /St. Andrew's Bottineau Clinic (SAC) make a determination of my eligibility for caring program services at SAHC/SAC. I understand that the information which I submit will be subject to verification by SAHC/SAC, and if the information which I submit is determined to be false, it will result in a denial of caring program services.

Services not eligible for the caring program include but are not limited to: Non Medically Necessary Services such as cosmetic lesion removal, Mammography services, etc....

1. Name: _____
First Middle Last
 Address: _____
Number and Street City State Zip Code
 Date of birth: _____ Marital Status: Single Married Widow Divorced
 Telephone: _____ Cell Phone: _____
 Occupation: _____ If student-estimated graduation date _____
 Employer: _____ Phone: _____

2. Spouse Name: _____
First Middle Last
 Occupation: _____ If student-estimated graduation date _____
 Employer: _____ Phone: _____

3. Income: **A) List total gross income for household/residents below.**
B) You MUST provide a copy of your most recent Federal Income Tax return (or complete a Form 4506-T to verify that you did not file Federal Income Tax)
C) And, after July 1st (or if recently employed) provide us with verification of income for the last 3 months or up through your first recent pay stub.

Total For Last 12 Months

<u>Self</u>	<u>Spouse-(Co-habitant)</u>
Wage Income..... _____	Wage Income..... _____
Farm or Self-Employment..... _____	Farm or Self-employment..... _____
Social Services (Food Stamps, AFDC, etc.).... _____	Social Services (Food Stamps, AFDC)..... _____
Social Security..... _____	Social Security..... _____
Unemployment Compensation..... _____	Unemployment Compensation..... _____
Worker's Compensation..... _____	Worker's Compensation..... _____
Strike Benefits..... _____	Strike Benefits..... _____
Alimony..... _____	Alimony..... _____
Child Support..... _____	Child Support..... _____
Military Family Allotments..... _____	Military Family Allotments..... _____
Pension..... _____	Pension..... _____
Income from Dividends, Interest, Rent..... _____	Income from Dividends, Interest, Rent..... _____
Other..... _____	Other..... _____
Sub Total _____	Sub Total _____

TOTAL: _____

4. Assets:

Land & Real Estate.....

* Do you own a home on up to 160 acres or more out of town (homestead exemption), or more than two acres in town? Y / N

* Do you have more than \$3,000 equity in other real estate property? Y / N

Saving Account(s)/CD's.....

* Do you have cash, savings, redeemable stocks and bonds, or other liquid assets exceeding 2 months income? Y / N

Other Assets.....

* Do you own more than one motor vehicle per licensed adult and/or working individual? Y / N

* Do you have other assets such as recreational vehicles (snowmobiles, ATV, jet skies, etc) valued in excess of: \$2,000 for family of 1, \$4,000 for family of 2, plus \$1,000 for each additional family member? Y / N

If you answered yes, please list what type: _____ and how many: _____

5. **Health Insurance:** Do you have any type of health insurance such as Blue Cross, Medicare, Medicaid, or commercial insurance? Yes No If yes, please specify below:

Insurance name _____ Policy # _____

Insurance name _____ Policy # _____

6. **Dependents:** Household dependents that are claimed on tax return.

Dependents over 18 must show proof of disability and verification of income

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If additional room is needed, please use the back of this page)

Return completed form with verification of income by _____.

I affirm that the information listed in this Request is true and correct to the best of my knowledge. I hereby authorize St. Andrew's Health Center/St. Andrew's Clinic to investigate any information provided and I authorize the release of any information that SAHC/SAC deems necessary in making an eligibility determination. I understand that providing false or misleading information on this application could result in the revocation of any Caring Program benefits applied to my balances with SAHC/SAC and result in the reinstatement of my full account balances due immediately, in full.

Signature (Person Making Request)

Date

TO BE COMPLETED - FACILITY PERSONNEL ONLY

This document was received on _____ by _____

**St. Andrew's Health Center/St. Andrew's Bottineau Clinic
Caring Program Determination**

Name: _____

Medical Record #: _____

Name: _____

Medical Record #: _____

Name: _____

Medical Record #: _____

Name: _____

Medical Record #: _____

Name: _____

Medical Record #: _____

1. Income:

- A. Total all income for last 12 months (Tax Return) \$ _____
- B. Total estimated income (3 month verification) \$ _____
- C. Total eligible family members' _____

2. Applicants statement of income was verified at the time of the determination by:
(List documents used for determination)

3. The applicant is: _____ Approved _____ Denied

Approved for _____ %
Dates of coverage: From _____ to _____

4. Reason for denial
- _____ Income Level too high
 - _____ Assets too great
 - _____ Has health insurance
 - _____ Lacks income verification
 - _____ Other (explain: _____)

5. The type of services requested: _____

Date of determination of eligibility for Caring Program: _____

Date the applicant was notified of determination: _____

Date notification letter and Caring Card were sent to applicant: _____

Date notification to Community Resource Coordinator, SAHC Billing Clerk, Clinic _____

Signed _____
CFO – Clinic Manager

**St. Andrew' Health Center/St. Andrew's Bottineau Clinic
Policy and Procedure
Caring (Charity) Program**

2011 HHS Poverty Guidelines
(Effective 1-31-2011)

Family Size	100%	75%	50%	25%	0%
1	10,890	13,613	16,335	19,058	21,780
2	14,710	18,388	22,066	25,744	29,422
3	18,530	23,163	27,796	32,429	37,062
4	22,350	27,938	33,526	39,114	44,702
5	26,170	32,713	39,256	45,799	52,342
6	29,990	37,488	44,986	52,484	59,982
7	33,810	42,263	50,716	59,169	67,622
8	37,630	47,038	56,446	65,854	75,262

***More than eight (8) members in the family, add \$3,820 for each additional family member.

Source: Federal Register, Vol. 71, No. 15, January 20, 2011, pp. 3637-3638

Revised 1-28-11jm