



Mountrail County Medical Center
P.O. Box 399
Stanley, ND 58784-0399
Phone: (701) 628-2424 Fax: (701) 628-2231

APPLICATION FOR PAYMENT REDUCTION/ SLIDING FEE

Applicant's Name _____ Phone # _____

Date of Birth _____ Social Security # _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Previous Address, if less than 3 years _____

Marital Status: _____ Married _____ Unmarried

Name & Address of nearest relative not living with you: _____

Employment Status: _____ Retired _____ Full Time _____ Part Time _____ Unemployed

Employer Name _____ Address _____

Phone # _____ Title/Position _____

How long employed: _____ How often paid _____

Take home salary per month _____

Previous Employer Name and Address _____

AMOUNT REQUESTED FOR PAYMENT REDUCTION/CHARITY CARE

HOSPITAL \$ _____ CLINIC \$ _____

AMOUNT YOU ESTIMATE YOU SHOULD BE ABLE TO PAY ON YOUR ACCOUNT:

HOSPITAL \$ _____ CLINIC \$ _____

Alimony, child support, or separate maintenance income need not be revealed if you do not wish to have it considered as a basis for repaying this obligation.

Alimony, child support, separate maintenance received under:

_____ Court Order _____ Written Agreement _____ Oral Understanding

JOINT APPLICANT OR OTHER PARTY INFORMATION

Name _____ Date of Birth _____

Employment Status _____ Retired _____ Full Time _____ Part Time _____ Not Employed

Spouse's Employer _____ Address _____

Phone # (____) _____ Title/Position _____

How Often Paid _____ Take home salary per month _____

I am responsible for the support of the following:

Dependents	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Insurance _____ Policy # _____
_____ Policy # _____

INFORMATION REQUIRED: COPIES OF YOUR MOST RECENT FEDERAL AND STATE INCOME TAX RETURNS AND PROOF OF THE LAST THREE MONTHS INCOME.

I authorize investigation of all matters contained in this payment reduction application and agree that if, in the judgment of Mountrail County Medical Center any misrepresentation or omission has been made by me or the results of such investigation are not satisfactory, this payment reduction application will be withdrawn immediately. I hereby release the designated hospital personnel and all parties who supply information at the request of the hospital personnel from liability for any acts of commission or omission, communications, or disclosures, which are made pursuant to such an investigation.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____