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 # _____

<u>INFORMATION REQUIRED:</u> 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been made by me or the results of such investigation are not satisfactory, this payment reduction application will be withdrawn immediately.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 _____

Plain Language Summary of Financial Assistance Policy (FAP)

Mountrail County Medical Center is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government healthcare benefit program or otherwise unable to pay for their care based on their individual financial situation and are within Mountrail County Medical Center's established guidelines for eligibility and availability of resources. Mountrail County Medical Center will provide, without discrimination, care for emergency medical conditions to individuals regardless of their ability to pay or whether they are financial assistance eligible.

A. Financial Assistance Guidelines

- Financial Assistance is only available for emergency medical care and medically necessary care provided by a Mountrail County Medical Center facility (see the financial assistance policy for the definition of medically necessary). Elective procedures, supplies, and non-medically necessary services are not covered under the program. Services not billed by Mountrail County Medical Center are not eligible for the program.
- FA is available to legal residents of the United States and who has been a legal resident of the Mountrail County Medical Center's service area for at least six months at the time services are provided.
- Financial assistance is available for an episode of care that has occurred within the last 240 days and/or up to 6 months after the approval of the financial assistance application.
- Eligibility is determined after reviewing an applicant's financial circumstances, as discussed below.
- All alternative payer resources, including governmental payers (i.e. Medicaid, IHS, etc.), must be exhausted prior to applying for financial assistance

B. Required Documentation for Mountrail County Medical Center Financial Assistance:

To be considered complete, a submitted application must include the following:

- Completed and Signed Financial Assistance application
- Two forms of valid ID, one must be a photo ID (see FAP for full list of acceptable forms of ID).
- Two forms as proof of residency. Must have applicant's full name and physical address (see FAP for full list)
- Approval/Denial letter from Medicaid, if applicable.
- Copy of most recent Federal Tax Return (Form 1040 or equivalent), including all schedules
- Two months of complete bank statements, both checking and savings accounts
- Verification of current income, if applicable. Examples include the two most recent pay stubs, pension and retirement benefits, Social Security benefits, unemployment compensation, Workers Compensation, Veteran's benefits, etc.

If an individual has no source of income, a letter of hardship and/or a letter of support will be accepted. Other documentation may be requested by Mountrail County Medical Center to verify information on the Financial Assistance application.

C. Program Qualifications

Financial assistance will be given to an individual if their household annual gross income (AGI) meets the following criteria. Annual Gross Income includes the annual income of the individual and all immediate family members who reside with them.

- An individual is not eligible for financial assistance if their household's combined Adjusted Gross Income (AGI) is greater than 200% of Federal Poverty Guidelines (FPG).
- An individual with AGI at or below these thresholds qualifies for 100% financial assistance.

An individual who qualifies for financial assistance will not be required to pay more for emergency medical care and other medically necessary care than the amounts generally billed to individuals who have insurance covering such care.

D. Accessing/Applying for the Financial Assistance Policy(FAP)

- Copies of the Financial Assistance Policy and application are available online at http://www.stanleyhealth.org/resources
- Copies of these documents are also available at Mountrail County Medical Center's Emergency Room and all admissions areas.
- All documents are provided free of charge.
- To obtain copies of these documents, in person or by mail, ask questions, receive assistance with completing a financial assistance application, or submit a completed Financial Assistance Application, contact Mountrail County Medical Center's Business Office through the following methods:
  - A. Phone: 701-628-2424
  - B. Fax: 701-628-3990
  - C. In Person: Mountrail County Medical Center, 615 6th St. SE, Stanley, ND 58784

Mountrail County Medical Center

2025 Poverty Guidelines for 48 Contiguous States & the District of Columbia

Person in Family	Poverty Guideline	200% of the Federal Poverty Guideline
1	$15,650	$31,300
2	$21,150	$42,300
3	$26,650	$53.300
4	$32,150	$64,300
5	$37,650	$75,300
6	$43,150	$86,300
7	$48,650	$97,300
8	$54,150	$108,300

The ratio is matched to the following chart, to determine the amount of eligibility for financial assistance.

Ratio	Assistance Percentage
0% - 200%	100%
200% - Over	0%

Approval Date: March 27, 2025