SOUTHWEST HEALTHCARE SERVICES
12 6th Ave. SW ~ Bowman, North Dakota 58623 ~ (701) 523-3226

FINANCIAL ASSISTANCE APPLICATION

Phone: (701) 523-7179 ~ Fax: 701-523-7126

LAST NAME OF RESPONSIBLE PERSON (print)	FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER		AGE
STREET ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER ☐ Full Time ☐ Part Time	WORK PHONE NUMBER	MONTHLY GROSS INCOME	

LAST NAME OF SPOUSE / SIGNIFICANT OTHER (print)	FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER		AGE
EMPLOYER ☐ Full Time ☐ Part Time	WORK PHONE NUMBER	MONTHLY GROSS INCOME	

RESPONSIBLE PERSON'S OTHER INCOME	SPOUSE/SIGINIFICANT OTHER INCOME	ANNUAL GROSS HOUSEHOLD INCOME
$	$	$
NUMBER OF CHILDREN IN FAMILY	TOTAL NUMBER IN FAMILY	AGES OF DEPENDENT CHILDREN

Have you applied for Medicaid and/or County Assistance?…… ☐ **Yes** ☐ **No**

Applicant must apply for Medicaid prior to application processing - Please attach a copy of your denial letter.

A copy of the following information must be included with your application. Proof of income required.

- ☐ Federal Tax Return (*most recent*) - If claimed as dependent by someone else, must provide claimants most recent tax return.
- ☐ 3 Months Current Pay Stubs - must include Responsible Person and Spouse / Significant Other.
- ☐ 2 Months of bank statements - must include all bank accounts

Other Income Source - attach supporting documents

☐ Alimony	☐ Food Stamps/Housing	☐ Railroad Retirement	☐ VA Assistance
☐ Child Support	☐ Life Insurance	☐ Social Security	☐ Worker's Compensation
☐ Disability	☐ Pension	☐ Unemployment	☐ Other - list:_____

Assets		**Liabilities**		**Expenses**	
Cash on Hand--checking……	$	Bank Loan Totals……	$	House Payment/Rent……	$
Cash on Hand--savings……	$	Credit Card Totals……	$	Bank Loan Payments……	$
Stocks, Bonds, and /or		Home Mortgage Loans……	$	Utilities……	$
Retirement Funds……	$	☐ Rent ☐ Own	$	Telephone……	$
Vehicle:_____Year:_____	$	Other Liabilities:_____	$	Cable TV……	$
Vehicle:_____Year:_____	$	Other Liabilities:_____	$	Medical Bills……	$
Home-estimated market value……	$	Other Liabilities:_____	$	Prescription Drugs……	$
Other Assets_____	$	Other Liabilities:_____	$	Insurance……	$
Other Assets_____	$			Groceries……	$
		Total Liabilities……	$	Child Care/Child Support……	$
Total Assets……	$	**Net Worth**(Assets-Liabilities)	$	Other:_____	$
				Total Monthly Expenses……	$

I acknowledge the information given to Southwest Healthcare Services is true and correct to the best of my knowledge. I authorize Southwest Healthcare Services to verify any or all the information given and to obtain a consumer credit report to be obtained as necessary.

If you have questions, call Patient Financial Services at (701) 523-7179, Monday - Friday, 8:00 a.m. - 4:30 p.m.

Responsible Person/Spouse/Significant Other Signature **Date**

Notes

OFFICE USE ONLY

☐ **Approved** **Dates approved:** _____
[Previous 18 months, 3 months in the future]

☐ **Not Approved**

☐ **Letter sent to applicant**

_____ _____
CFO **Financial Counselor**

_____ _____
CEO **Business Office Manager**