HEART OF AMERICA
MEDICAL CENTER

Heart of America Medical Center
2975 Hwy 2 E
Rugby, ND 58368
(701) 776-5261

Community Care Application Instructions

Heart of America Medical Center (HAMC) provides free or discounted care to those who have no means or limited means (Uninsured or Underinsured) to pay for medical services. Financial assistance may include full or partial assistance, write-off or reduced monthly payments. HAMC provides financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full.

If assistance is needed at any time during the application process, please contact us Monday through Friday, 8:00 a.m. to 4:30 p.m. CST at 701-776-5455 ext. 2392. In-person support is also available at the Business Office, 2975 Highway 2 East, Rugby, ND 58368.

To process your application, please submit a completed and signed (by both you and your spouse/significant other) application along with the following documentation:

- **Proof of Residency**:
  - Lease or mortgage agreement, property tax bill, or current utility bill for electric, gas or water. *Note: Cell phone bills, medical bills, bank statements and credit card statements cannot be accepted*.
- **A complete copy of your most recent tax return**
- **Income Verification**:
  - Copy of the three (3) most recent pay stubs, unemployment benefits, or social security benefits letter.
  - Any additional income such as alimony, child support, rents, royalties, annuities, estates, trusts, or inheritance.
- **Proof of Assets**:
  - Copy of the three (3) most recent bank statements for all checking, savings and investment accounts.

Family Income: Family income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines: Includes earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and miscellaneous sources.

- Noncash benefits (such as heating assistance and housing subsidies) do not count.
- Determined on a before-tax basis.
- Excludes capital gain or losses; and
- If a person lives with a family, it includes the income of all family members (non-relatives, such as housemates, do not count).

Services not eligible for Community Care program include, but are not limited to non-medically necessary services, cosmetic services and living center.

See full Policy for a comprehensive list.

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Community Care Application

Applicant's Name			
Name (First, Middle, Last):	Date of Birth:	Social Security Number:	
Address:		Apt #:	
City:	State:	Zip Code	Household Size:
Marital Status: ( ) Single	( ) Married	( ) Widow	( ) Divorced
Home Phone:	Cell Phone:		
Employment Status: ( ) Full Time	( ) Part Time	( ) Self Employed	( )Unemployed ( )Student
Occupation:	Unemployed Date/Length (mm-dd-yyyy)		
Employer Name:	Employer Phone:		
Employer Address:	Length of Employment:		

Spouse/Partner Information			
Name (First, Middle, Last):	Date of Birth:	Social Security Number:	
Address:		Apt #:	
City:	State:	Zip Code	Household Size:
Marital Status: ( ) Single	( ) Married	( ) Widow	( ) Divorced
Home Phone:	Cell Phone:		
Employment Status: ( ) Full Time	( ) Part Time	( ) Self Employed	( )Unemployed ( )Student
Occupation:	Unemployed Date/Length (mm-dd-yyyy)		
Employer Name:	Employer Phone:		
Employer Address:	Length of Employment:		

Dependent (other than spouse) Information			
Name:	Date Of Birth:	Name:	Date Of Birth:

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Name:	Date Of Birth:	Name:	Date Of Birth:
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Family Household Income		
Monthly Income	**Self**	**Spouse/Partner**
Wage Income: Monthly ___ Weekley___ Biweekly ____	$	$
Self-Employment or Farm	$	$
Social Security/SSI/SSD	$	$
Unemployment Compensation	$	$
Social Services (Food Stamps, AFDC, WIC, etc.)	$	$
Worker's Compensation	$	$
Alimony/Child Support	$	$
Retirement Benefits/Pension/Railroad Retirement	$	$
Rental Income/Royalties	$	$
Trusts/Inheritance/Estates	$	$
Income from Interest/Dividends/Stocks/Bonds	$	$
Other:	$	$
Total	$	$
TOTAL MONTHLY INCOME	$	

Account Type	Bank Name	Account Holder's Name
Checking Account		
Savings Account		
Checking Account		
Saving Account		

Insurance Information		
Do you have Insurance	( ) Yes	( ) No
Name of Insurance:		
If no Insurance have you applied for Medicaid?	( ) Yes	( ) No
If denied, provide a copy of the denial letter.		

Any other information you would like to include for us to take into consideration: _____

_____

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_____

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I affirm that the information listed in the Request is true and correct to the best of my knowledge. I hereby authorize HAMC to investigate any information provided and I authorize the release of any information that HAMC deems necessary in making an eligibility determination. By signing this agreement, I promise to cooperate with HAMC staff and provide adequate information in a timely manner to get my bill resolved. Providing any false information will disqualify applicant from program participation.

Applicant Signature _____ Date _____

Spouse/Partner Signature _____ Date _____