SOUTHWEST HEALTHCARE SERVICES
Southwest Medical Clinic
12 6th Ave SW
PO Box C
Bowman, ND 58623

CARE APPLICATION

SECTION A

Responsible Party: _____
Last Name First Name M.I. Date of Birth

Billing Address: _____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Place of Work: _____ Work Phone: _____

Social Security #: _____

SECTION B

Please complete table for individuals in the household:
Note: (DO NOT list individuals that the responsible party is not LEGALLY responsible for)

Last Name, First Name	Date of Birth	Does person have health coverage?	Insurance Carrier: Medicaid, Medicare, BCBS, etc.	Policy/ID Numbers
		☑ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

SECTION C

Please list income of all adult household members who are employed:

Person Employed	Company Name	Income Before Taxes	How Often? (Circle)
		$	☐ Monthly / Yearly ☐
		$	☐ Monthly / Yearly ☐
		$	☐ Monthly / Yearly ☐

OTHER SOURCES OF INCOME - Please indicate if income is per week/month/year/etc.

Pension/Retirement	$ /	Alimony	$ /	TANF	$ /
Disability Pay	$ /	Child Support	$ /	SSI	$ /
Unemployment	$ /	Other	$ /	Soc. Security	$ /

NOTE: Include income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment, alimony, child support, military, unemployment, public aid, etc.

SECTION D

Please read carefully before signing:

Proof of Income:

Proof of income is required. By signing below, I agree that Southwest Healthcare Services (SWHS) staff may contact each employer of all people working in the home and/or may contact other agencies to confirm the income listed. Within 30 days, I will give SWHS a copy of all information requested for all people in the home to see if I qualify for reduced fees.

UN-EMPLOYED/NO INCOME APPLICANTS

Non-income applicants must complete the non-income verification form. (see page 3 of application)

I will be asked to reapply for the program the beginning of each year, therefore SWHS may have a current billing form on file. I will update my application if the people living in my home change, our income changes, or our insurance changes. If I do not send in proof of information or provide correct information, I may not be eligible for reduced fees.

**I understand that any ancillary tests, to include laboratory and radiology services, done at Southwest Healthcare Services will not qualify for Sliding Fee Scale. Additional financial assistance paperwork will be required for ancillary tests.

Signature _____ Date _____

NOTES

_____

_____

_____

_____

_____

_____

_____

SWHS Use Only

☐ Approved Dates approved: _____

☐ Not Approved % Discount: _____

☐ Letter sent to applicant

CFO _____ Financial Counselor _____

CEO _____ Business Office Manager _____

Un-Employed/Non-Income Verification for Sliding Fee Scale

(Please Print)

Name of Patient _____ Date _____

Name of 3rd Party _____

Phone Number of 3rd Party _____

Address of 3rd Party _____

_____

_____

I, _____, certify to my best knowledge that _____, a patient at SWHS, has no income at this time.

Signature of 3rd Party _____ Date _____

*SWHS requires proof of no income; we require a 3rd party signature verifying the applicant is unemployed. Please have a non-relative that is at least 18 years of age sign above.

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