Linton Regional Medical Center
PO Box 850 - 111 Elm Ave W
Linton, ND 58552
Phone: 701-254-4511
Fax: 701-254-0112

Community Caring Program Application

Return all applications to:
Linton Regional Medical Center
111 Elm Ave W
PO Box 850
Linton, ND 58552
Phone: 701-254-4511

Linton Regional Medical Center is dedicated to providing health care to our patients, regardless of their ability to pay for these services. We realize that payment of these services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance. The hospital utilizes the Federal Income Poverty Guidelines to provide the eligibility determinations. Eligibility determinations are based on the gross (before any deductions) yearly household income and not expenses.

This form will need to be submitted as soon as possible. Please make every effort to return your application within two weeks of receiving. This form must be completed every 12 months or if your financial situation changes.

In order for this application to be processed you must include:

1. The enclosed application completed in its entirety.
2. Copies of the last three (3) months income for all wage earners contributing to your household income. Bank statements will be accepted as verification of income.
3. Copy of your most recent income tax return.
4. Gross household income must be accurately stated for everyone that lives in the household. Gross income is your income before taxes or deductions of any type are taken out of your wages. If income is left blank or reported inaccurately, the form will be considered invalid and the application will be denied.
5. For individuals that are separated, you must report the income the absent spouse contributes to the household.
6. For additional information on income requirements, please see the “Community Caring Program Policy” for further detail or call Linton Regional Medical Center’s business office at 701-254-4511.
7. Signature is required for form to be valid. If a Power of Attorney or the guardian of a minor is completing the form, the person completing the form is required to sign it along with their relationship to the patient.
8. Once your application is procced you will receive a letter in the mail informing you of the outcome.

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Please call the Business Office at 701-254-4511 to assist you with questions regarding this application.

PART 1: Demographic Information

Guarantor Name: ____________________ Birthdate: ____________________

Mailing Address: ____
Street City State Zip

Guarantor Employment: ____________________ Job Title: ____________________

PART 2: Monthly Source of Income – Represents all sources before taxes

Please use the lines below to list **everyone living in your household** and their income if they have one. Gross income is your income prior to any taxes or any other item being deducted from your total wages. Please fill out all requested information on each line used below.

**If separated, must include amount of income the absent spouse contributes to the household. $____________

	Name	Relationship to Patient	Age	Employer Name	Gross Income per Month
1.					
2.					
3.					
4.					
5.					
6.					

COMBINED MONTHLY GROSS INCOME: $ ____________

PART 3: Income Taxes

- ☐ I have not filed for income taxes in the past year due to a low–income status.
- ☐ I am up to date on filing for income taxes and have enclosed latest return.

PART 4: Additional Comments

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Assignment of Rights (Please read carefully)

By signing below, I certify that the information contained in this application and the documentation which I have submitted are accurate, true, and correct to the best of my knowledge.
I understand that Linton Regional Medical Center may make reasonable requests for additional information and verification if necessary.
I understand that the information and documentation provided will be kept confidential.
I understand the Linton Regional Medical Center made no representation that financial assistance is guaranteed.
I hereby certify the above information is correct

Guarantor/Applicant's Signature: ____ **Date:** ______________

Relationship if other than the patient: ____ **Date:** ______________