McKenzie County Healthcare Systems, Inc.
Financial Assistance / Sliding Fee Schedule Application

It is the policy of McKenzie County Healthcare Systems, Inc., to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the business office representative to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at the clinic and/or hospital, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every six months. Please inquire at the front desk if you have questions.

NAME OF HEAD OF HOUSEHOLD		PLACE OF EMPLOYMENT		
STREET	CITY	STATE	ZIP	PHONE
HEALTH INSURANCE PLAN		SOCIAL SECURITY NUMBER		

Please list self, spouse, and dependents under age 18:

Household Size							
RELATION	**SELF**	**SPOUSE**	**CHILDREN**	**CUSTODIAL PARENT OF CHILD**	**FOSTER CHILD**	**LEGAL RESPONSIBILITY OTHER**	**TOTAL**
Number of members							

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Annual Household Income				
SOURCE	**SELF**	**SPOUSE**	**OTHER**	**TOTAL**
Gross Wages, Salaries, Tips, Etc.				
Social Security, Pension, Annuity, and Veteran's Benefits				
Alimony, Child Support, Military Family Allotments				
Income from Business, Self-Employment, and Dependents				
Rent, Interest, Dividend, and Other Income				
TOTAL INCOME				

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

NAME (PRINT)	
SIGNATURE	DATE

Office Use Only

Patient Name		Discount	
Date of Service		Approved by	

VERIFICATION CHECKLIST (ATTACH COPIES)	**YES**	**NO**
Identification/Address: Driver's License, Birth Certificate, Employment ID, Social Security Card or Other	☐	☐
Income: Prior Year Tax Return, Three Most-Recent Pay Stubs, or Other	☐	☐
Insurance: Insurance Cards	☐	☐
Medicaid: Application Made or Evidence of Rejection	☐	☐

Office Use Only

Patient Name		Discount	
Date of Service		Approved by	