



**SOUTHWEST HEALTHCARE SERVICES**

14 Sixth Avenue Southwest ~ PO Box C  
Bowman, ND 58623

**FINANCIAL ASSISTANCE APPLICATION**

Phone: 701-523-7117 ~ Fax: 701-523-7107

LAST NAME OF RESPONSIBLE PERSON (print)	FIRST NAME	MIDDLE INITIAL	
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER	AGE	
STREET ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER <input type="checkbox"/> Full Time <input type="checkbox"/> 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 <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	WORK PHONE NUMBER	MONTHLY GROSS INCOME	

RESPONSIBLE PERSON'S OTHER INCOME \$	SPOUSE/SIGNIFICANT 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 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.

**Other Income Source** - attach supporting documents

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Alimony       | <input type="checkbox"/> Food Stamps/Housing | <input type="checkbox"/> Railroad Retirement | <input type="checkbox"/> VA Assistance         |
| <input type="checkbox"/> Child Support | <input type="checkbox"/> Life Insurance      | <input type="checkbox"/> Social Security     | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> Disability    | <input type="checkbox"/> Pension             | <input type="checkbox"/> Unemployment        | <input type="checkbox"/> 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 .....\$ _____	<input type="checkbox"/> Rent <input type="checkbox"/> 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 ..... \$ _____	<b>Total Liabilities</b> .....\$ _____	Groceries ..... \$ _____
<b>Total Assets</b> .....\$ _____	<b>Net Worth (Assets-Liabilities)</b> \$ _____	Child Care/Child Support..... \$ _____
		Other: ..... \$ _____
		<b>Total Monthly Expenses</b> ..... \$ _____

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 Services at (701) 523-7117 or (701) 523-7163, Monday - Friday, 8:00 a.m. - 4:30 p.m.

\_\_\_\_\_  
Responsible Person/Spouse/Significant Other Signature Date

