MOBRIDGE REGIONAL HOSPITAL & CLINICS
DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED SERVICES

This application must be completed annually. Applicant must be ineligible for other healthcare programs such as Medicaid, Disability, etc. Verification of income must be supplied, and all other information requested.

Date of Request: _____

Full Name (first, middle, last):		
Address (house number, city, state, zip):		
Phone:	Occupation:	Employer:
Employer address:		

Income: List income for family from all sources

	Total last 12 mo	Total last 3 mo		Total last 12 mo	Total last 3 mo
Wages			Farm/Self Employed		
Public Assistance			Social Security		
Unemployment Compensation			Worker's Comp		
Alimony			Child Support		
Military Family Allotments			Pensions		
Rental Income			Other (describe):		

Asset Information:
Checking Account (balance, name of bank):_____
Savings Account (balance name of bank):_____
Family Size:

Name:	Name:	Name:	Name:
Relationship:	Relationship:	Relationship:	Relationship:

At least one of the following forms of income verification must be provided with this application(please check which one(s) enclosed):
[]Signed Federal Income Tax Return(most recent filed year) []W-2 Withholding Forms(1040) []Pay Stubs(one month)
[]Approval/Denial Form for Worker's Compensation []Oral or written verification from Public Welfare Agency/ County Social Services

I understand that the information included on and with this application is true and correct to the best of my knowledge. I authorize the Mobridge Regional Hospital to check my credit and employment history. I understand that if this information is false, I will be held responsible for the charges for services provided to me.

Signature: _____
Date: _____