107 12th St. S
Cooperstown, ND 58425
Phone: 701-786-1700

APPLICATION FOR COMMUNITY CARE

General Instructions:

This application is to be considered for the Community Care program which helps to cover your medical costs. Your answers will largely determine whether you and/or the person for whom you are applying are eligible. Application assistance is also available at no cost on-site with the Business Office or by calling (701) 786-1700. An electronic version of the policy and application are also available at www.dakotaregional.com.

Your answers must give a true and complete statement of facts. If they are not, the form will be returned to you for more information. You could be asked to prove the accuracy of all your statements.

The following documents must be attached:

- Tax return and supporting schedules (previous year)
- Three months of most recent pay stubs (Three for each adult applying)

PERSONAL APPLICANT INFORMATION

Name: _____
First Middle Last

Mailing address: _____ _____ ___ _____
Street City St. Zip

Date of birth: _____ Phone: (____) _____- _____
Mo. Day Yr.

HOUSEHOLD SIZE

Please list all members that are currently living in your household who you financially responsible for and are claimed on your tax return.

Name	Relationship	Date of Birth

TO BE COMPLETED BY FACILITY PERSONNEL ONLY

This document was received by: _____ on date: _____

INSURANCE

Do you have any type of health insurance such as Medicare, Medicaid, or Commercial insurance (ex. BCBS)? If yes please specify below for each member of your household, please attach documentation if necessary. (This is to ensure we have billed your account properly)

Insurance Name:_____ Policy #_____ Group # _____

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INCOME

Please review the list of different forms of income and enter the amount received in your household wither weekly, monthly or annually. If you do not receive them you do not need to write anything on the line.

	Weekly	Monthly	Annually
Wage Income	$	$	$
Other Income	$	$	$

OTHER

Please let the committee know of any information you would like considered not contained in this form:

COMMUNITY CARE AUTHORIZATION

Signature of applicant: _____ Date: _____

TO BE COMPLETED BY FACILITY PERSONNEL ONLY

This document was received by: _____ on date: _____