MOBRIDGE REGIONAL HOSPITAL & CLINICS
DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED SERVICES

This application must be completed annually. 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):		

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: _____