



400 East First Street • Morris, MN 56267 • 320-589-1313 • www.scmcinc.org

STEVENS COMMUNITY CARE APPLICATION

PATIENT / RESPONSIBLE PARTY INFORMATION

Name _____
Address _____
City/State/Zip _____
Phone _____
DOB _____
Spouse's Name _____
DOB _____

CURRENT MEDICAL INSURANCE

Insurance Company _____
Policy # _____ Effective Date _____
Medicare # _____ Effective Date: _____
Medicaid # _____ Effective Date _____
Are you a Minnesota Senior Federation member? _____

DEPENDENTS Use an additional sheet if necessary

Name(s)	Date(s) of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MONTHLY INCOME (Gross Income)

Patient \$ _____
Spouse \$ _____
Interest/Dividends \$ _____
Child support/Other \$ _____
TOTAL \$ _____

EMPLOYMENT INFORMATION

Patient: Employed Self-Employed Unemployed Retired
Spouse: Employed Self-employed Unemployed Retired

BANK INFORMATION

Bank Name _____
Savings Balance \$ _____ Checking \$ _____
Total Value of Liquid Assets \$ _____

This information is true and correct to the best of my knowledge, and I authorize SCMC to process my application. I agree to notify SCMC of changes to my insurance coverage, employment, dependent or other income information. SCMC reserves the right to ask customers to re-apply. If I have applied for MNSure or other Medical Assistance programs I authorize SCMC to discuss my information with those affiliates as needed to coordinate my potential insurance coverage.

Date _____ Applicant's signature _____
Date _____ Spouse's signature _____
Date _____ SCMC Administrative Approval _____

Eligible _____ Non-Eligible _____