4a. Financial Assistance Application Check List
(For those filling out entire form)

Please be sure that you have answered all the questions on the application and included copies of required documents.

- ❑ Did you and your spouse sign and date the application?
- ❑ Did you enclose your most recent tax returns (federal and state), all pages and schedules, including W-2s?
- ❑ If you did not enclose a copy of your tax returns, why? _____
- ❑ Did you enclose copies of your earnings statements for the last 3 months?
- ❑ Did you enclose copies of all award letters for unemployment, financial aid for college, or general assistance?
- ❑ Did you enclose a copy of your Social Security check or copy of award letter?
- ❑ Did you enclose a copy of each of your last three bank statements?
- ❑ Did you enclose a copy of each of your last three pension/investment account statements (savings, CDs, stocks, etc.)?
- ❑ Did you write a letter explaining your need for financial assistance?

You may also qualify for the Medication Assistance Program (MAP) for your prescription needs. To make an appointment with a MAP advocate, please call (406) 446 -2345 or 1(877) 404-9442.

4b. Release of Information Authorization for Financial Assistance
(For ALL Applicants)

I certify that the information I provided is true and correct to the best of my knowledge. I will cooperate to obtain assistance and pay Beartooth Billings Clinic any money I receive.

I will provide Beartooth Billings Clinic with information about any other means to pay this bill such as Medicaid, Crime Victims Fund, automobile or home insurance policies, etc. I will cooperate with Beartooth Billings Clinic to obtain assistance from any government agency and will pay Beartooth Billings Clinic any money I receive relating to these medical services. I release Beartooth Billings Clinic and its representatives from any and all liability connected with this release of information.

_____ _____
Signature of Applicant (Patient, Parent or Guardian) Date

_____ _____
Signature of Spouse Date

Mailing Address:
Beartooth Billings Clinic
Attn: PFS Financial Assistance
PO Box 590
Red Lodge, MT 59068

REV 04/13 4059884

Questions? Call Patient Financial Representatives: (406)446-2345 or toll free 1(877) 404-9442.

Beartooth Billings Clinic

Financial Assistance Application

In keeping with our mission and core values, Beartooth Billings Clinic is committed to providing health care for people regardless of their ability to pay.

You may apply for financial assistance for you and your family if you do not have health insurance, or are concerned that you may be unable to pay for all or part of your health care services.

We will work with you to see if you qualify for other health insurance programs, interest-free payment plan options, long-term loans, or our Financial Assistance Program. If you qualify for financial assistance, some or all of your balances may be reduced for medically-necessary services only. Beartooth *Billings Clinic will determine if a service is medically necessary based on the Beartooth Billings Clinic Financial Assistance Policy.*

1a. Household Information

Applicant: _____

Spouse: _____

Address: _____
Number and Street

_____
City State Zip Code

Home Phone: (_____) _____

Cell Phone: (_____) _____

Occupation: (You) _____

Date of Birth: _____

Social Security No.: _____

Employer: _____

Employer Address: _____

Phone: (_____) _____

Occupation: (Spouse) _____

Date of Birth: _____

Social Security No.: _____

Employer: _____

Employer Address: _____

Phone: (_____) _____

Other members living in the household:
(Add more on another sheet of paper)

_____
First and Last Name
_____
Relationship
_____
Date of Birth

_____
First and Last Name
_____
Relationship
_____
Date of Birth

_____
First and Last Name
_____
Relationship
_____
Date of Birth

_____
First and Last Name
_____
Relationship
_____
Date of Birth

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

1b. Are you currently receiving benefits for any of the public assistance programs listed below?

If so, you may automatically qualify for Financial Assistance. Please provide proof with a current copy of confirmation of eligibility for one program (such as a letter of approval or copy of monthly coverage). Check the box for the program(s) you participate in:

- ❑ Supplemental Nutrition Assistance Program (SNAP), also called Food Stamps
- ❑ Women, Infants and Children programs (WIC)
- ❑ Subsidized/low income housing assistance
- ❑ Low Income Energy Assistance Program (LIEAP)
- ❑ State-funded low income prescription programs
- ❑ Homeless, or receiving care from a homeless clinic

If you checked a box, skip to page 4 and sign part b.
If not, go to page 2.

Questions? Call Patient Financial Representatives: (406)446-2345 or toll free 1(877) 404-9442.

If you are not currently receiving benefits for any of the public assistance programs listed on page 1b, please complete the remainder of this form.

To be considered for financial assistance, you must supply the following:

- ❑ Completed and signed application form
- ❑ Copies of most recent year's tax returns (federal and state), all pages and schedules, including W-2s
- ❑ Copies of earnings statements for the applicant and his/her spouse for the last three (3) months (pay stubs, Social Security, unemployment, retirement, pensions, child support, federal student aid)
- ❑ One copy of each of your last three bank statements
- ❑ One copy of each of your last three pension/investment account statements (savings, CDs, stocks, etc.)
- ❑ Letter explaining your need for financial assistance

Without the above listed items, your application could be denied as incomplete.

Please return this signed application and the above listed items within four (4) weeks. We will notify you in writing of our decision within 45 days of receiving a complete application. You have the right to appeal our determination.

Income - List all monthly gross income	Applicant	Spouse	Other	Total
Gross wages from paycheck				
Farm or self employed				
Social Security/SSI/SSDI				
Unemployment compensation				
Workers compensation				
Alimony				
Child support				
Pension/retirement				
Income from dividends, interest, rent				
Education grants/loans				
Inheritance				
Oil and mineral royalties/land lease				
Native American income				
Income tax refunds: ❑ federal ❑ state				
Settlement income: ❑ worker's comp. ❑ bodily injury ❑ lawsuit ❑ other ❑ motor vehicle accident				
Other income (please explain) _____				
Total				

❑ If you are currently unemployed, when was your last day of work? _____

❑ Will you receive unemployment? Yes ____ No ____

❑ If you are temporarily out of work, do you expect to return to the same job? Yes _____ No ____

If so, when _____

Assets - Financial (*Accounts I Own*)	Current Balance	Financial Institution Holding Account	Account #
Checking account			
Savings account #1			
Savings account #2			
CDs/bonds			
Stock/mutual funds			
Retirement funds			
Other: (Please List)			

Total A

For internal use only

Total Assets A + B1

Total Liabilities B2 + C1

Total Monthly Payments B3 + C2 + D

Assets - Property (*Property I Own*)	Current Value of Property	Amount Owed on Property	Monthly Payment (if loan associated with property)
House			
Auto #1			
Auto #2			
Auto #3			
RV			
Boat			
Motorcycle/ATV			
Rental property			
Other: (Please List)			

Total B1 B2 B3

Liabilities (*Balances I Owe*)	Current Balance of Loan	Monthly Payment
Bank or credit union loans		
Credit cards		
Department store cards		
Outstanding medical bills		
School loans		
Other: (Please List)		

Total C1 C2

Monthly Expenses	Amount
Rent	
Groceries/household products	
Lights & heat	
Phone (cell & home)	
Water & sewer	
Gasoline	
Insurance (health, home, auto, life, renter's, etc.)	
Child care	
Child support	
Clothing	
Entertainment including TV, internet, movies, etc.	
Prescriptions	
Other: (Please List)	

Total D