



Policy and Procedure Manual:  
Benefis Hospitals, Inc.  
Benefis Community Hospitals, Inc.  
Benefis Medical Group

Policy Code #  
Title: Benefis Health System Financial Assistance Policy

Effective Date: 02/2020  
Revision Date: 02/12/2020  
Supersedes:  
03/2019

Approved by:

Benefis Health System Boards of Directors  
Date

Forrest Ehlinger                      02/12/2020  
Date

Chief Financial Officer  
Date

\_\_\_\_\_  
Date  
(Month/Yr.)

**I. Purpose:**

Benefis Health System, Inc. and its affiliates (collectively, “Benefis”) are not-for-profit, tax-exempt entities with a charitable mission of providing emergency and medically necessary health care services to residents of Benefis Health System service area regardless of their financial status and ability to pay. The purpose of this Financial Assistance Policy is to ensure that processes and procedures exist for identifying and assisting hospital patients whose care may be provided without charge or at a discount commensurate with their financial resources and ability to pay. This Policy applies to each hospital facility owned or operated by a Benefis affiliate, including without limitation Benefis Hospitals, Inc. in Great Falls, Montana, and Benefis Community Hospitals, Inc. (Benefis Teton Medical Center) in Choteau, Montana (in each case, the “Hospital”). This policy also applies to professional services provided by Benefis Medical Group physicians.

**II. Overview:**

In furtherance of its charitable mission, the Hospital will provide both (i) emergency treatment to any person requiring such care; and (ii) medically necessary health care services to patients who are permanent residents of the Benefis Health System service area (and others on a case-by-case basis) who meet the conditions and criteria set forth in this policy; in each case, without regard to the patients’ ability to pay for such care.

The Hospital will provide financial assistance (care either for free or at discounted rates) to persons or families where: (i) there is limited or no health insurance available; (ii) the patient fails to qualify for governmental assistance (for example, Medicare or Medicaid); (iii) the patient cooperates with the Hospital in providing the requested information demonstrating financial need, or other facts and circumstances readily demonstrate financial need; and (iv) the Hospital makes an administrative determination that financial assistance is appropriate based on the patient's ability to pay (as established by family income or based on criteria demonstrating presumptive eligibility) and the size of the patient's medical bills.

After the Hospital determines that a patient is eligible for financial assistance, the Hospital will determine the amount of financial assistance available to the patient by utilizing the Financial Assistance Guidelines (set forth as **Exhibit 1**). The Guidelines reflect family income levels tied to the most recent Federal Poverty Guidelines, and establish corresponding discount percentages. The Guidelines are to be adjusted annually to reflect the annual update to the Federal Poverty Guidelines, and to adjust the corresponding discount percentages to ensure that, in all cases, a patient determined to be eligible for financial assistance will not be billed more than the amounts generally billed (AGB) by the Hospital for the same emergency or medically necessary services to individuals who have insurance covering such care.

Benefis will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the mission of Benefis; (ii) explains the decision processes of who may be eligible for financial assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to patients who are uninsured or otherwise eligible.

### **III. Nondiscrimination:**

- A.** The Hospital will render health care services, inpatient and outpatient, to all Montana residents who are in need of emergency or medically necessary care, regardless of the ability of the patient to pay for such services and regardless of whether and to what extent such patients may qualify for financial assistance pursuant to this policy.
- B.** The Hospital will not engage in any actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

- C. US Citizenship and Residency Requirement** Applicants for charity care shall provide the hospital with proof of US citizenship. The applicant shall provide the hospital with any of the identification documents listed in the identification section that contains the applicant's current residence address and a date from which the hospital can reasonably infer that the applicant has resided in the US during the time of service, has no residency in any other country, and has the intent to remain in the State. The hospital may accept an attestation from the applicant that he or she is homeless. If the applicant is unable to provide these documents, the hospital staff shall document why the applicant was unable to comply and issue a determination of ineligible until which time the patient meets one of these requirements for proof of citizenship.

**IV. Definitions:**

- A. Assets:** Cash or any item of economic value owned by the patient that can be readily converted into cash. Examples are cash, savings and checking accounts, certificates of deposit, treasury bills, stocks, bonds or other securities, accounts receivable, inventory, equipment, a house (other than primary residence), a car, and other property. For these purposes, assets do not include a primary residence or other property exempt from judgment under Montana law, or any amounts held in pension or retirement plans (although distributions and payments from such plans may be included as family income for purposes of this policy)
- B. Bad Debt Expense:** Uncollectible accounts receivable (where reasonable attempts to collect have been made), excluding contractual adjustments, arising from the failure to pay by patients: (i) whose health care has not been classified as financial assistance care; or (ii) who have qualified for financial assistance in the form of discounted care but have failed to pay the remaining balances due after application of discounts pursuant to this policy.
- C. Family:** The patient, his or her spouse (including a legal common-law spouse), any minor children supported by the patient, and any adults for whom the patient is legally responsible. In the case of a minor patient, family includes both parents, the spouse of a parent, minor siblings, and any adults for whom the patient's guarantor is legally responsible. If a patient or guarantor has been abandoned by a spouse or parent, that spouse or parent shall not be included as a family member. A pregnant female counts as two family members.
- D. Family Income:** The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. Family income includes gross wages, salaries, dividends, interest, Social Security benefits, workers' compensation, veterans' benefits, training stipends, military allotments, regular support from family members not living in the household (other than child support),

government pensions, private pensions, insurance, annuity payments, income from rents, royalties, estates, trusts, and other forms of income.

- E. Financial Assistance:** Either full or partial reduction in charges to patients for emergency or medically necessary care, in the case of patients who are Financially Eligible, Presumptively Eligible, or Medically Indigent, as those terms are defined in this policy. Financial assistance does not include bad debt or contractual shortfalls from government programs, but may include insurance co-payments, deductibles, or both.
- F. Financially Eligible:** A patient who meets both of the following criteria: (i) the patient's family income is at or below 400% of the Federal Poverty Guidelines, as set forth in Exhibit 1 hereto; and (ii) the patient's individual assets as of the date of service or of application do not exceed \$7,500, and the patient's family assets do not exceed \$15,000 as of the date of service or of applications demonstrated based, in each case, on factual information provided by the patient on the Financial Assistance Application.
- G. Medically Indigent:** A patient who incurs catastrophic medical expenses is classified as Medically Indigent when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.
- H. Medically Necessary:** Any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Medicare. Medically necessary services do not include: (i) non-medical services such as social and vocational services; (ii) elective cosmetic surgeries (for these purposes, cosmetic plastic surgery procedures designed to correct appearance for personal reasons are not considered "elective"); (iii) gastric bypass surgeries; (iv) tubal ligations and/or vasectomies; or (v) convalescent care.
- I. Patient:** As applicable depending on context, either the patient or his or her guarantor, *i.e.*, the person having financial responsibility for payment of the account balance.
- J. Presumptively Eligible:** A patient who has not submitted a completed Financial Assistance Application, but who nonetheless is subject to one or more of the following criteria:
- Homeless
  - Deceased with no estate
  - Mentally incapacitated with no one to act on his or her behalf
  - Medicaid eligible, but not on the date of service or for non-covered services
  - Enrolled in one or more governmental programs for low-income individuals having eligibility criteria at or below 200% of the Federal Poverty Guidelines

- Incarceration in a penal institution

The Hospital's trained Financial Service Representatives will routinely review the foregoing criteria with patients, before asking patients to complete the Financial Assistance Application. The Hospital may also utilize other software programs or automated systems to determine Presumptive Eligibility. Patients who meet any of the foregoing criteria for Presumptive Eligibility will be deemed to be eligible for a 100% discount, and will not be asked or required to submit a Financial Assistance Application.

**V. Eligibility for Financial Assistance:**

- A. Financial assistance will be given for emergency or medically necessary services to patients who are Financially Eligible or Medically Indigent (in both cases, based on information provided via the Financial Assistance Application attached as **Exhibit 2**), or to patients who have been determined to be Presumptively Eligible. In addition, financial assistance may be provided in other circumstances on a case-by-case basis as determined by the Benefis CFO in his or her discretion.
- B. A determination of qualification for financial assistance will cover services provided by the Hospital on an inpatient or outpatient basis. For these purposes, the policy also covers the rendering of professional services by physicians and other providers employed directly by the Hospital as listed on **Exhibit 3**. A determination of qualification for financial assistance will also cover professional services rendered by the other physicians and providers set forth on **Exhibit 4**, all of whom participate in the provision of emergency and/or medically necessary care at the Hospital and have agreed to be covered by this policy. Any other physicians or providers of care at the Hospital are not subject to this policy and, accordingly, each patient will be responsible for satisfaction or resolution of any bills issued by such physicians or providers for their professional services.
- C. Where possible, prior to the admission or rendering of service, a Financial Service Representative will conduct an interview with the patient, the guarantor, and/or his other legal representative. If an interview is not possible prior to the admission or rendering of service, the interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the evaluation of payment alternatives may not take place until the required medical care has been provided.
- D. At the time of the initial patient interview, the Financial Service Representative will gather routine demographic information and information regarding all existing third-party coverage. In cases where a patient has limited or no third-party coverage, the Financial Service Representative will determine if the patient qualifies for medical assistance from other existing financial resources such as Medicare, Medicaid, crime

victims compensation funds, Montana Marketplace, or other state and federal programs. The Financial Service Representative will be available to assist the patient with enrolling in any governmental payment programs that may be available. If the patient refuses to apply for or provide information necessary to the application process, he or she will be ineligible for financial assistance pursuant to this policy. If the application(s) to the above-mentioned medical financial assistance resource(s) is(are) denied, not adequate, or was(were) previously denied, or if the Hospital has not received a response from the applicable medical financial assistance resource within 7 months of submission of a completed application, consideration for financial assistance will then be given. In cases where third-party coverage (including private insurance or payment by governmental program) is nonexistent or likely to be inadequate, the Financial Service Representative will inform the patient of the availability of financial assistance. However, in cases where third-party coverage is denied because the patient failed to comply with the insurer's stated pre-certification requirements and or coordination of benefit requirements, the patient will be ineligible for financial assistance pursuant to this policy.

- E. Patients seeking financial assistance will be asked to complete the Financial Assistance Application attached as **Exhibit 2** to this policy. Copies of the application form are available from any Financial Service Representative and at <https://www.benefis.org/patients-visitors/patients/billing-insurance/financial-assistance>. Applications may be completed directly by the patient, by the patient's guarantor and/or other legal representative, or by a Financial Service Representative based on information derived from any of the foregoing through an interview either in person or by telephone, or reliable information provided in writing. If assistance is needed with gathering necessary information or materials requested as part of the financial assistance qualifying process, patients are encouraged to contact one of the Hospital's trained Financial Service Representatives at 406-455-3557 or *Benefis Teton at 406-466-6003*. Financial Service Representatives may also assist patients with assessing their financial situations, gathering information requested by the Hospital, and assisting with similar tasks.
- F. Patients completing the Financial Assistance Application must return the signed form and required supporting materials through any of the following measures:
- Hand-deliver to a Patient Service Representative or to the Patient Financial Services Office at either:
    - Benefis Hospitals, 1101 26th Street South, Great Falls, MT 59405, or
    - Benefis Teton Medical Center, 915 Fourth St. N.W., Choteau, MT 59422
  - Mail to Benefis Health System, Attn: Patient Financial Services, Attn: FAP, 1101 26th Street South, Great Falls, MT 59405 or to:
  - Benefis Teton Medical Center, 915 Fourth St. N.W., Choteau, MT 59422

Financial Assistance Applications will be considered if received at any time during the 240-day period following the first post-discharge billing statement issued by the Hospital to the patient for such care.

- G. Eligibility for financial assistance is conditioned upon (i) the patient's provision of complete and accurate information on the Financial Assistance Application set forth as **Exhibit 2**, (ii) the patient's participation in an education session with a Patient Service Representative regarding insurance options available through the Montana Insurance Marketplace (health insurance exchange), Montana HELP, and (iii) the patient's timely cooperation throughout the financial assistance application process. In connection with determining a patient's eligibility for financial assistance, the Hospital will not request information other than as described on **Exhibit 2**, although patients may voluntarily provide additional information that they believe to be pertinent to eligibility. If the Hospital contacts the patient to request missing information, the patient will have a period of 30 days to respond. Failure to respond within that 30-day period will result in the Application being suspended from further processing; the patient may re-activate the Application by providing the requested information at any time during the 240-day period following the first post-discharge statement issued by the Hospital to the patient for such care. If a patient provides information that is inaccurate or misleading, he or she may be deemed ineligible for financial assistance and, accordingly, may be expected to pay his or her bill in full.
- H. Once a completed Financial Assistance Application is received, the Financial Service Representative will review the application and forward it to the Patient Accounts Manager/Director for approval. Patients who are determined to be Presumptively Eligible will be processed for financial assistance without need for completion of the Financial Assistance Application or other additional information from the patient.
- I. Patients who are uninsured and who do not qualify for financial assistance may contact the Hospital to discuss payment options, including the availability of a payment plan. Financial Service Representatives will inform such patients of any other discounts that may be available under other Benefis policies.

**VI. Determination and Notification Regarding Financial Assistance:**

- A. In the case of patients who are determined to be Financially Eligible, patients with family income at or below 200% of the current Federal Poverty Guidelines will receive a 100% reduction in the patient portion of billed charges (*i.e.*, full write-off), as set forth on **Exhibit 1**. Patients with family income between 201% and 400% of the current Federal Poverty Guidelines will receive a sliding-scale discount on the patient portion of the billed charges, as indicated on **Exhibit 1**; *provided, however*, an uninsured patient will receive the greater of the 40% Self-Pay Discount (per the Benefis Health System Self-Pay Discount Policy) or the discount for which the patient qualifies under **Exhibit 1** to this Policy. In the case of patients who are determined to be Medically Indigent, the patient will receive a 100% write-off of

charges exceeding 30% of gross family income and/or an appropriate discount determined by the Director of Revenue Cycle and the Benefis CFO after review on a case by case basis of annual family income; the 30% threshold needs to be met only once per family in a 12-month period. Patients who are determined to be Presumptively Eligible for financial assistance will receive a 100% reduction in charges (full write-off).

- B. The applicable discount percentage from **Exhibit 1** will be applied to the gross charges otherwise billable to the patient. Such discounts have been established in a manner intended to comply with applicable Federal law, which prohibits the Hospital from billing a patient eligible for financial assistance more than the amounts generally billed (“AGB”) by the Hospital to patients with third-party coverage, calculated in this case using the look-back method set forth in applicable Treasury Regulations, considering amounts allowed by Medicare and commercial payors during a prior 12-month measurement period. The discount percentages set forth on **Exhibit 1** may be adjusted periodically (and at least annually) to ensure that such percentages comply with the foregoing standards under Federal law; any such adjustments will be effectuated through the attachment of an updated **Exhibit 1** to this Policy, which will be signed and dated by the Benefis CFO. The Hospital will begin applying the adjusted discount percentages not later than 120 days after the end of the 12-month measurement period with respect to which the Hospital’s adjusted AGB has been calculated.
- C. The provision of financial assistance (*i.e.*, the amount of the discount or write-off) will follow the PBS Write off Policy for approval(s).
- D. Within 15 business days after submission of a completed Financial Assistance Application, the Hospital will determine whether the patient qualifies for financial assistance based on Financial Eligibility or Medical Indigence and will notify the patient in writing of such determination and the amount of the discount to be provided; if the patient is uninsured, the written notice will indicate that the financial assistance award is conditional upon meeting with a Financial Service Representative to learn about insurance options available through the Montana Health Insurance Marketplace. Unless otherwise determined by the Benefis CFO, the Hospital need not notify patients determined to qualify for financial assistance based on Presumptive Eligibility. In the event that the Hospital determines a patient not to qualify for financial assistance, the Hospital will notify the patient in writing of such determination, including the basis for the denial; the notice will state that the patient may reapply if the patient’s financial circumstances have changed so as to make the patient Financially Eligible in connection with future services.
- E. Except as provided below, all determinations of qualification for financial assistance will be effective for a period commencing 8 months prior to the date of the completed Financial Assistance Application and continuing until the date that is 6 months following the date of the completed Financial Assistance Application. Accordingly, if a patient has qualified for financial assistance within the last 6 months and the patient’s financial circumstances, family size, and insurance coverage have not changed, the patient will be deemed to have qualified



for financial assistance with respect to additional emergency or medically necessary care, without having to submit a new Financial Assistance Application. However, if a patient has qualified for financial assistance but then experiences a material change in his or her financial circumstances and/or insurance status that may impact his or her continued qualification for financial assistance, the patient will be expected to communicate that change to the Hospital within 30 days or, in any event, prior to obtaining further healthcare services. Alternatively, the Hospital may request an update of the information provided on the Financial Assistance Application and, based on such updated information, may re-evaluate the patient's continued qualification.

#### **VII. Impact on Billing and Collection Process:**

- A.** Patients qualifying for discounted, but not free, care will be notified in writing regarding any remaining balance due. The patient may be asked to schedule an appointment with a Financial Service Representative to arrange payment terms. Any such remaining balances will be treated in accordance with Patient Accounts policies regarding self-pay balances. Payment terms will be established on the basis of disposable family income.
  
- B.** In the event that a patient qualifies for financial assistance but fails to timely pay the remaining balance due (including, if applicable, per the terms of the agreed-upon payment plan), the Hospital may take any of the actions set forth in the Benefis Health System Self Pay Billing and Collection Policy, a copy of which is available <https://www.benefis.org/media/file/Benefis%20Billing%20and%20Collection%20Policy%2012%202019.pdf>. Consistent with the Self Pay Billing and Collection Policy, the Hospital will not undertake any extraordinary collection actions (as defined in that Policy) without first making reasonable efforts to determine a patient's eligibility for financial assistance pursuant to this policy.

#### **VIII. Publication:**

- A.** The existence and terms of this Financial Assistance Policy will be made widely available to residents of the Hospital's primary and secondary service areas. In furtherance of the foregoing, the Hospital will utilize and widely distribute the plain-language summary attached as **Exhibit 5** to this Policy. Copies of such plain-language summary (i) will be included in patient registration materials and inpatient handbooks, (ii) will be offered to each patient as part of the intake or discharge process, and (iii) will be posted on the Hospital's website, along with this Policy and the Financial Assistance Application, in a prominent and easily accessible location. This Policy, the plain-language summary, and the Financial Assistance Application will be available in English and any other language that is the primary language of the lesser of (i) 1,000 individuals, or (ii) 5% of the population within the Hospital's primary and secondary service areas.

- B. The Hospital will conspicuously post, in the Patient Admitting and Registration areas as well as the Emergency Department, signage providing information regarding the availability of financial assistance and describing the application process. Such signage will include the following statement: *You may be eligible for financial assistance under the terms and conditions the Hospital offers to qualified patients. For more information, ask your registration or patient service representative for more information.* Such signs will be in both English and any other language that is the primary language of the lesser of (i) 1,000 individuals, or (ii) 5% of the population within the Hospital's primary and secondary service areas. Such signage will be posted in other areas throughout the Hospital's facilities offering meaningful visibility.
- C. The Hospital will cause each billing statement sent to a patient to include a conspicuous statement regarding the availability of financial assistance, including (i) a phone number for information about this policy and the application process, and (ii) a website address where this policy, the Financial Assistance Application, and the plain-language summary are available. As provided in the Billing and Collection Policy, if the Hospital intends to undertake any extraordinary collection action (as defined in the Billing and Collection Policy), the Hospital will ensure that at least one billing statement (the Pre-Collection Letter, as defined in the Billing and Collection Policy) includes a copy of the plain-language summary of this Financial Assistance Policy, as set forth on **Exhibit 5**, with such copy provided at least 30 days prior to undertaking the anticipated extraordinary collection action.

**IX. Budgeting, Recordkeeping, and Reporting:**

- A. The Benefis CFO will ensure that reasonable financial assistance, including both free care and discounted charges, is included in the Hospital's annual operating budget. The budgeted amount will not act as a cap in providing financial assistance, but will serve as a projection to aid in planning for the allocation of resources.
- B. The Hospital will cause completed Financial Assistance Applications (along with required supporting information) to be maintained in Patient Financial Services Office records. Such records will also reflect information as to whether such Applications were approved or denied.
- C. Financial assistance provided by the Hospital pursuant to this Policy will be calculated and reported annually as required under applicable law. Except as otherwise specifically permitted based on context, the Hospital will report its financial assistance provided to qualifying patients under this policy using the cost of services provided (not the charges for the associated services), with cost determined by applying the total cost-to-charge ratio derived from the Hospital's Medicare cost report.

**X. Confidentiality:**

The Hospital recognizes that the need for financial assistance may be a sensitive and deeply personal issue for patients. Confidentiality of information and preservation of individual dignity will be maintained for all who seek financial assistance pursuant to this Policy. No information obtained in the patient's Financial Assistance Application may be released except where authorized by the patient or otherwise required by law.

**XI. Staff Information/Training:**

- A. The Hospital will cause all employees in the Patient Financial Services Office and Patient Admitting and Registration areas to be fully versed in this Financial Assistance Policy, to have access to this Policy as well as the plain-language summary and Financial Assistance Application forms, and to be able to direct questions to the appropriate Hospital office or representative.
- B. The Hospital will cause all staff members with public and patient contact to be adequately trained regarding the basic information related to this Financial Assistance Policy and procedures. They will also be able to direct questions regarding this Policy to the appropriate Hospital office or representative.

**XII. Other Related Policies:**

- A. Billing and Collection Policy
- B. Self-Pay Discount Policy
- C. Prompt-Pay Discount Policy

**Attachments:**

- Exhibit 1 Financial Assistance Guidelines and AGB Calculation
- Exhibit 2 Financial Assistance Application
- Exhibit 3 Employed Physicians and Providers Covered by Policy
- Exhibit 4 Other Physicians and Providers at Hospital Covered by Policy
- Exhibit 5 Plain-Language Summary of Financial Assistance Policy

**EXHIBIT 1**  
**2020 FPL FINANCIAL ASSISTANCE GUIDELINES AND AGB CALCULATION**

2020 Federal Poverty Guidelines (FPG)

Family or Household Size	100% FPG	200% FPG	250% FPG	300% FPG	350% FPG	400% FPG
	<i>Free Care</i>	<i>Free Care</i>	<i>80% Discount</i>	<i>70% Discount</i>	<i>60% Discount</i>	<i>55% Discount</i>
1	\$12,760	\$25,520	\$31,900	\$38,280	\$44,660	\$51,040
2	17,240	34,480	43,100	51,720	60,340	68,960
3	21,720	43,440	54,300	65,160	76,020	86,880
4	26,200	52,400	65,500	78,600	91,700	104,800
5	30,680	61,360	76,700	92,040	107,380	122,720
6	35,160	70,320	87,900	105,480	123,060	140,640
7	39,640	79,280	99,100	118,920	138,740	158,560
8	44,120	88,240	110,300	132,360	154,420	176,480

- Add \$4,420 for each Additional Person
- The foregoing discount percentage has established in a manner intended to comply with applicable Federal law, which provides that the hospital may not bill a patient eligible for financial assistance more than the amounts general billed ("AGB") by the Hospital to patients who have insurance covering such care. The Hospital has calculated its AGB using the look-back method set forth in applicable Treasury Regulations, considering amounts paid by Medicare and Commercial payors.
- The Hospital will recalculate its AGB periodically (and at least annually) and, based thereon, may adjust the discount percentages set forth above. Any such adjustments will be effectuated through a revision to this exhibit, which will be signed and dated by the Benefits CFO.

Signed: \_\_\_\_\_

Forrest Ehlinger, CFO

## EXHIBIT 2



### Financial Assistance Application

## FINANCIAL ASSISTANCE PROGRAM

As part of our mission, Benefis Health System (including Benefis Hospitals in Great Falls and Benefis Teton Medical Center in Choteau) is committed to providing access to quality health care for residents of the State of Montana, and to treating all our patients with dignity, compassion and respect.

Our Financial Assistance Program provides services without charge, or at significantly discounted prices, to eligible patients who cannot afford to pay for part or all of their care. Our Financial Assistance Program provides discounts up to 100 percent of hospital/physician charges to patients who meet financial eligibility guidelines.

When applying for Financial Assistance, your cooperation is needed in providing the information and supporting documentation necessary for us to make a fair and timely decision. If complete and accurate information is not provided, your application may be rejected or denied without further review, in which case you will be expected to pay your bill in full.

Given the sensitive nature of these requests, all communication with the patient or family members will be handled in strict confidence and in a compassionate manner.

Thank you for selecting Benefis for your health care needs. We take pride in serving the health care needs of Montana residents!

This Financial Assistance Application is being provided to you for completion so that we can determine if you qualify for our Financial Assistance Program.

**COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY**

**If you do not complete this application packet or if you return it without the requested supporting documentation, we will be unable to determine whether you qualify for our Financial Assistance Program. In that case, you will be responsible for the full balance due on your account.**

**If you need help in completing this form or gathering the supporting materials, please contact a Benefis Financial Service Representative at 406-455-3557 or Benefis Teton at 406-466-6003.**

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ✓ A copy of a photo ID (state driver's license/state ID) or other identification documents (Social Security card, alien registry card, birth certificate, baptismal or marriage certificate, passport, visa, employee ID card, etc.).
- ✓ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ✓ Last two weeks of paystubs with year to date totals, or last two months of paystubs without year to date totals (if paid in cash without paystubs, provide written verification from employer).
- ✓ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, wage and earning statement from Social Security office
- ✓ , etc.
- ✓ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter, a copy of your monthly Social Security check, or copies of bank statements from three months prior showing direct deposit of the Social Security benefit.
- ✓ Copies of bank statements for checking, savings, certificates of deposit, etc. for the last two months.
- ✓ A copy of a current utility bill, telephone bill, or cable television bill from the residence at which you reside.
- ✓ If you are a student, a list of the current semester's credits/classes and a copy of your student ID.

👉 NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.

👉 NOTE: Where parents of a minor patient are divorced or separated but share responsibility for the minor's medical care, each parent must complete a separate application.

**Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided**



## FINANCIAL ASSISTANCE APPLICATION

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

### I. PERSONAL INFORMATION

Personal information of applicant (or parent, if applicant is a minor):

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street City State Zip Code

Living at Address Since \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

List family members (including parents, patient, and natural or adoptive siblings) living at above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

### II. INSURANCE INFORMATION

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan:		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Veteran's Benefits? (Y/N)		





**III. EMPLOYMENT AND INCOME INFORMATION**

**Employment information of applicant (or parent, if applicant is a minor):**

Employer \_\_\_\_\_ Unemployed? (Y/N) \_\_\_\_\_ Date of Unemployment \_\_\_\_\_

Business Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # (\_\_\_\_\_) \_\_\_\_\_ Does Employer Offer Health Insurance ? (Y/N) \_\_\_\_\_

Occupation / Position \_\_\_\_\_ Date of Hire \_\_\_\_\_

Student (Y/N) \_\_\_\_\_ Name of School \_\_\_\_\_ Number of Credits This Semester \_\_\_\_\_

MONTHLY SALARY				HOURLY PAY		HOURS WORKED WEEKLY	
GROSS	\$	NET	\$	\$			

Additional Source(s) of Income (per month):

- |                                              |          |                                         |          |                                              |          |
|----------------------------------------------|----------|-----------------------------------------|----------|----------------------------------------------|----------|
| <input type="checkbox"/> Other wages         | \$ _____ | <input type="checkbox"/> Child Support  | \$ _____ | <input type="checkbox"/> Self Employment     | \$ _____ |
| <input type="checkbox"/> Interest, Dividends | \$ _____ | <input type="checkbox"/> Pension/Ret'mt | \$ _____ | <input type="checkbox"/> SSI/Social Security | \$ _____ |
| <input type="checkbox"/> Rental Income       | \$ _____ | <input type="checkbox"/> Worker's Comp  | \$ _____ | <input type="checkbox"/> Veterans Benefits   | \$ _____ |
| <input type="checkbox"/> Food Stamps         | \$ _____ | <input type="checkbox"/> Unemployment   | \$ _____ | <input type="checkbox"/> Other               | \$ _____ |
| <input type="checkbox"/> Alimony             | \$ _____ | <input type="checkbox"/> Farm Income    | \$ _____ |                                              |          |

**Employment information of Spouse (if applicable):**

Spouse's Employer \_\_\_\_\_ Unemployed ? (Y/N) \_\_\_\_\_ Date of Unemployment \_\_\_\_\_

Business Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # (\_\_\_\_\_) \_\_\_\_\_ Does Employer Offer Health Insurance ? (Y/N) \_\_\_\_\_

Occupation / Position \_\_\_\_\_ Date of Hire \_\_\_\_\_

Student (Y/N) \_\_\_\_\_ Name of School \_\_\_\_\_ Number of Credits This semester \_\_\_\_\_

MONTHLY SALARY				HOURLY PAY		HOURS WORKED WEEKLY	
GROSS	\$	NET	\$	\$			

Additional Source(s) of Income (per month):

- |                                              |          |                                         |          |                                              |          |
|----------------------------------------------|----------|-----------------------------------------|----------|----------------------------------------------|----------|
| <input type="checkbox"/> Other wages         | \$ _____ | <input type="checkbox"/> Child Support  | \$ _____ | <input type="checkbox"/> Self Employment     | \$ _____ |
| <input type="checkbox"/> Interest, Dividends | \$ _____ | <input type="checkbox"/> Pension/Ret'mt | \$ _____ | <input type="checkbox"/> SSI/Social Security | \$ _____ |
| <input type="checkbox"/> Rental Income       | \$ _____ | <input type="checkbox"/> Worker's Comp  | \$ _____ | <input type="checkbox"/> Veterans Benefits   | \$ _____ |
| <input type="checkbox"/> Food Stamps         | \$ _____ | <input type="checkbox"/> Unemployment   | \$ _____ | <input type="checkbox"/> Other               | \$ _____ |
| <input type="checkbox"/> Alimony             | \$ _____ | <input type="checkbox"/> Farm Income    | \$ _____ |                                              |          |



**IV. MONTHLY EXPENSE INFORMATION**

Indicate monthly amounts paid or owed on items below:

RENT / MORTGAGE		HOUSEHOLD BILLS	
Landlord Name		Heat / Utilities	\$
Landlord Phone #	( )	Phone / Cell Phone	\$
Mortgage Lender		Cable TV / Internet	\$
Mortgage Amount	\$	Homeowner's Insurance	\$
		Auto Insurance	\$
<b>LOANS</b>		Health, Dental, Vision Insurance	\$
Auto Loans	\$	Life or Disability Insurance	\$
Personal Loans	\$	Other Insurance	\$
Student Loans	\$	Medical Bills (hospital / clinic)	\$
OTHER OBLIGATIONS		CREDIT CARDS	
Child Care	\$	Credit Card	\$
Child Support	\$	Credit Card	\$
Alimony	\$	Credit Card	\$
Other	\$		

TOTAL MONTHLY EXPENSES: \$ \_\_\_\_\_

**V. ASSETS**

Indicate current fair market value of any of the following:

BANK ACCOUNTS				REAL ESTATE OWNED	
Name of Bank		Value		\$	
Savings	\$	Street Address			
Checking	\$	City, State and ZIP			
VEHICLES OWNED				LIST OTHER ASSETS	
	Year/Make	Model	Value		\$
First			\$		\$
Second			\$		\$
Third			\$		\$

TOTAL ASSETS: \$ \_\_\_\_\_



**VII. CERTIFICATION**

*I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Benefis Health System, and I authorize Benefis Health System to contact third parties to verify the accuracy of the information I have provided. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.*

Applicant's Signature \_\_\_\_\_ Date of Request \_\_\_\_\_

Your completed application and supporting documentation may be submitted by:

- Hand-delivering to a Patient Service Representative or to the Patient Financial Services Office at either:
  - Benefis Hospitals East, 1101 26th Street South, Great Falls, MT 59405, or
  - Benefis Hospitals West, 500 15<sup>th</sup> Ave South, great Falls, Mt 59405
  - Benefis Teton Medical Center, 915 Fourth St. N.W., Choteau, MT 59422

Mailing to Benefis Health System, Attn: Patient Financial Services, PO Box 5096, Great Falls, MT 59405

**\*\*\* To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application \*\*\***

*Applicants will be notified within 15 business days after submission of a complete application with all required supporting documentation*

**EXHIBIT 3**

**Benefis Medical Group Employed Physicians and Other Providers Covered by Policy**

**All providers employed or contracted through Benefis Medical Group are covered under this policy, inclusive of providers providing services at Benefis Teton Medical Center.**

Please see <https://www.benefis.org/> for listing of physicians.

## **EXHIBIT 4**

### **Other Physicians and Providers Providing Care at Hospital *not* Covered by this Policy**

Physicians and other providers not employed in Exhibit 3 may participate in your care at Benefis Hospitals and Benefis Teton Medical Center, but are not subject to this Financial Assistance Policy. You will be billed directly by those providers for their professional services. Please contact those providers directly if you have questions or concerns regarding their bills for professional services.

## EXHIBIT 5



### Plain-Language Summary of Financial Assistance Policy

Benefis Hospitals, Benefis Medical Group Physicians (Great Falls) and Benefis Teton Medical Center (Choteau) will provide emergency and medically necessary healthcare services for free or at discounted rates to certain patients who are uninsured or have limited insurance available. Generally speaking, patients eligible for discounted charges must have family incomes under 400% of the Federal Poverty Guidelines, while patients eligible for free care must have family incomes under 200% of the Federal Poverty Guidelines; in both cases, patients must not have available assets above established thresholds. Financial assistance may also be available in other limited circumstances, depending on the size of the patient's medical bills and whether the patient meets certain other criteria for eligibility.

Patients seeking financial assistance may apply by completing a Financial Assistance Application. Copies of the Financial Assistance Application, as well as Benefis Health System's Financial Assistance Policy and Billing and Collection Policy, are available at <https://www.benefis.org/patients-visitors/patients/billing-insurance/billing-insurance>. Patients may also request free copies of the Application and these policies by mail, by calling *406-455-3557 or Benefis Teton Hospital at 406-466-6003*, or may obtain free copies in person at the Patient Financial Services Office at either:

- Benefis Hospitals, 1101 26th Street South, Great Falls, MT 59405, or
- Benefis Teton Medical Center, 915 Fourth St. N.W., Choteau, MT 59422

Completed Financial Assistance Applications and required supporting materials may be submitted by:

- Hand-delivering to a Patient Service Representative or to the Patient Financial Services Office at either Hospital address, as shown above
- Mailing to Benefis Health System, Attn: Patient Financial Services, 1101 26th Street South, Great Falls, MT 59405 or to:
- Benefis Medical Center, 916 Fourth St. N.W., Choteau, MT 59422

Persons seeking more information or needing assistance in completing the Financial Assistance Application may contact one of the Hospital's trained Financial Service Representatives in the Patient Financial Services Office at *406-455-3557 or Benefis Teton at 406-466-6003*.

A patient qualifying for financial assistance under Benefis Health System's Financial Assistance Policy will not be charged more than the amounts generally billed by the Hospital for the same services to individuals who have insurance covering such care.