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			
GROSS	$	NET	$

HOURLY PAY	$	HOURS WORKED WEEKLY	

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

❑ Other wages	$_____	❑ Child Support	$_____	❑ Self Employment	$_____
❑ Interest, Dividends	$_____	❑ Pension/Ret'mt	$_____	❑ SSI/Social Security	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ Veterans Benefits	$_____
❑ Food Stamps	$_____	❑ Unemployment	$_____	❑ Other	$_____
❑ Alimony	$_____	❑ 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			
GROSS	$	NET	$

HOURLY PAY	$	HOURS WORKED WEEKLY	

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

❑ Other wages	$_____	❑ Child Support	$_____	❑ Self Employment	$_____
❑ Interest, Dividends	$_____	❑ Pension/Ret'mt	$_____	❑ SSI/Social Security	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ Veterans Benefits	$_____
❑ Food Stamps	$_____	❑ Unemployment	$_____	❑ Other	$_____
❑ Alimony	$_____	❑ 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	$
LOANS		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 15th 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