

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	\$
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

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.