## Additional Information

Please provide any additional information that you would like to be considered as part of your application:

## Health Insurance

Do you have or expect to have health insurance?

Yes - start date _____

No - please explain _____

_____

For more information on health insurance, go to HealthCare.gov or call 1-800-318-2596

Would you like more information about the Healthy Montana Kids (HMK) program?

Yes ☐ No ☐

# Financial Assistance Application

No one will be denied access to medically necessary services based on inability to pay.

**For Services Provided By:**

Frances Mahon Deaconess Hospital

Glasgow Clinic Primary Care

Glasgow Clinic Specialty Care


FRANCES MAHON
DEACONESS HOSPITAL

621 3rd Street South
Glasgow MT 59230
406-228-3500
www.fmdh.org


# Payment Options

At Frances Mahon Deaconess Hospital, we understand that medical bills may occur when you least expect them. To help with these bills, please see options below.

**Please call (406) 228-3633 or (406) 228-3620.**

## Financial Assistance

Financial assistance is a discount on your bill, based on your income and assets minus debts. To apply, fill out this form and return with proof of income. To check if you may qualify, please refer to the chart on the right. Find your family size in the left hand column and look across to see where your total income falls. The actual amount of your discount may also depend on the value of your assets minus your debts.

### Annual Income

| Family Size | Discount | | | | | | Scale effective 03/15/24 |
|---|---|---|---|---|---|---|---|
| | 100% | 90% | 80% | 70% | 60% | 50% | 40% |
| 1 | $30,117 | $32,627 | $35,138 | $37,648 | $40,159 | $42,669 | $45,180 |
| 2 | $40,876 | $43,283 | $47,691 | $51,098 | $54,505 | $57,913 | $61,320 |
| 3 | $51,635 | $55,939 | $60,243 | $64,547 | $68,852 | $73,156 | $77,460 |
| 4 | $62,394 | $67,595 | $72,796 | $77,1997 | $83,198 | $88,399 | $93,600 |
| 5 | $73,153 | $79,251 | $85,348 | $91,446 | $97,544 | $103,642 | $109,740 |
| 6 | $83,912 | $90,906 | $97,901 | $104,896 | $111,891 | $118,885 | $125,880 |
| 7 | $94,671 | $102,562 | $110,454 | $118,345 | $126,237 | $134,128 | $142,020 |
| 8 | $105,429 | $114,218 | $123,006 | $131,795 | $140,583 | $149,372 | $158,160 |
| 9 | $116,188 | $125,874 | $135,559 | $145,244 | $154,929 | $164,615 | $174,300 |

**Elective services are excluded from this program. Refer to the interest free payment plans for these services.**

## Interest Free Payment Plans

We offer a monthly payment plan for up to 12 months without an application. To extend payments beyond 12 months, please fill out this application.

## Lump Sum Payment

We have smaller monthly payment plans that include a lump sum payment payable when an income tax refund or a farm payment is received.

## Application Checklist

☐ **Proof of Income**

- Paystubs or proof of other monthly income sources for the last 90 days. This could include social security income, pension benefits, etc.. (see Monthly Income Section)
- A complete copy of your most recent tax return(s) including all schedules.
- If you are claimed on another tax return, please provide that return as well.
- Any other information that may be necessary to qualify such as financial statements used for operating notes.

☐ **Fill in all fields, front and back**

☐ **Sign and date application**

☐ **Return within 10 days**

# Financial Assistance & Extended Payment Plan Application

**Please fill in all lines on this form**

Head of Household _____ Date of Birth_____ SS#_____

Spouse/Partner _____ Date of Birth_____ SS#_____

Street Address _____ City/State _____ Zip _____

Mailing Address _____ City/State _____ Zip _____

Telephone _____ Marital Status: Married Single Divorced Widowed (circle one)

Employer _____ How many years/months?_____

Spouse Employer _____ How many years/months?_____

Disabled? No/Yes (date) _____ Applied for Disability (date) _____

Dependents (please list first and last name):

Name_____ Relationship _____ Age_____
Name_____ Relationship _____ Age_____
Name_____ Relationship_____ Age_____

## Assets and Debts

| | Estimated Value | Amount Owing |
|---|---|---|
| Home (if owned): | | |
| Vehicles: | | |
| Year _____Model_____ | | |
| Year _____Model_____ | | |
| Year _____Model_____ | | |
| RV/ Boat/Motorcycle: | | |
| Year _____Model_____ | | |
| Year _____Model_____ | | |

Other Loans (Student Loans, Operating Loans, etc. ):

| Type | Amount Owed |
|---|---|
| | |
| | |

Checking Account Balance_____
Bank or Institution_____
Savings Account Balance_____
Bank or Institution_____

Investments (Please list any Stocks/Mutual Funds, Mineral Rights, IRAs, CDs, Rental Property, etc.)

1 _____ $_____
2 _____ $_____
3 _____ $_____
4 _____ $_____

Settlement Pending? Yes No $_____

Inheritance Pending? Yes No $_____

## Monthly Expenses

Rent or House Payment $ _____
Car Payments (total) $ _____
RV/Boat/Motorcycle (total) $ _____
Student Loan Payment $ _____
Other Loan Payment $ _____
Food $_____
Electricity/Gas $_____
Phone/Cell Phone/Internet $_____
Pharmacy/Drugs $_____
Water $_____
Cable/Satellite TV $_____
Insurance
- Auto $_____
- Health/Life $_____
- Property $_____

Car Expense/Gas $_____
Child Care $_____
Child Support/Alimony $_____
Other _____ $_____
Collections:
- Owing_____ Payment $_____

Credit Cards:
- Owing_____ Payment$_____

Doctor Name:_____
- Owing:_____ Payment $_____

Dentist Name:_____
- Owing:_____ Payment $_____

Hospital Name:_____
- Owing:_____ Payment $_____

Total $_____

## Monthly Income (proof of income required)

Employment (Gross Wages) $_____
Part-Time Jobs (Gross Wages) $_____
Social Security $_____
Social Security Disability $_____
Disability Pension $_____
Veteran Pension $_____
Retirement (all sources) $_____
Unemployment Compensation $_____
Workers Compensation $_____
Union Benefits $_____
Inheritance $_____
Public Assistance (TANF) $_____
Snap (Food Stamps) $ _____
Alimony/Child Support $_____
Rents/Royalties $_____
Savings Interest Income $ _____
Investment Income $ _____
Other _____ $_____

Total $_____

If you are claiming no income, how are you paying for living expenses? (please explain on back)

## Certification

The information provided in this application is true and correct to the best of my knowledge. Frances Mahon Deaconess Hospital may verify any of this information.

I understand additional information may be requested to qualify. False information will result in a denied application.

Signature, Head of Household Date

Signature, Spouse Date

Return completed application and proof of income to the FMDH Counselor's Office.