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 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.

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

Annual Income

Family Size	Discount							Scale effective 01/17/23
	100%	90%	80%	70%	60%	50%	40%	30%
1	$29,160	$31,201	$33,388	$35,429	$37,471	$39,512	$41,699	$43,740
2	$39,440	$42,201	$45,159	$47,920	$50,680	$53,441	$56,399	$59,160
3	$49,720	$53,200	$56,929	$60,410	$63,890	$67,371	$71,000	$74,580
4	$60,000	$64,200	$68,700	$72,900	$77,100	$81,300	$85,800	$90,000
5	$70,280	$75,200	$80,471	$85,390	$90,310	$95,229	$100,500	$105,420
6	$80,560	$86,199	$92,241	$97,880	$103,520	$109,159	$115,201	$120,840
7	$90,840	$97,199	$104,012	$110,371	$116,729	$123,088	$129,901	$136,260
8	$101,120	$108,198	$115,782	$122,861	$129,939	$137,018	$144,602	$151,680
9	$111,400	$119,198	$127,553	$135,351	$143,149	$150,947	$159,302	$167,100

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 _____

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 Patient Accounts Office.