Glendive Medical Center

# FINANCIAL ASSISTANCE
# Application Form

1. **Applicant Information.**

| Last Name First Name MI | Telephone Numbers: Home Work Cell |
|---|---|
| Street Address | City State Zip |
| Mailing Address (If different form Street Address) | — Male<br>__ Female / *Are you pregnant? Yes __ No __ . |
| Are you: Homeless? Yes __ No __ .<br>Unemployed? Yes __ No __ .<br>Uninsured? Yes __ No __ . | |

2. **If you are applying for someone else, complete this section.**

| Last Name First Name MI | Relationship to Applicant: |
|---|---|
| Street Address | Telephone Numbers: Home Work Cell |
| City State Zip | Mailing Address (If different from Street Address) |

3. **Family Information.**
List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

| Name of Family Member | Relationship | Date of Birth | Gender | Also applying for financial assistance? |
|---|---|---|---|---|
| | | | M_ F_ | Y_ N_ |
| | | | M_ F_ | Y_ N_ |
| | | | M_ F_ | Y_ N_ |
| | | | M_ F_ | Y_ N_ |
| | | | M_ F_ | Y_ N_ |

4. **Household Member (Non-family)**

| Name of Family Member | Relationship | Date of Birth | Gender | Also applying for financial assistance? |
|---|---|---|---|---|
| | | | M_ F_ | Y_ N_ |
| | | | M_ F_ | Y_ N_ |
| | | | M_ F_ | Y_ N_ |

5. **List Earned Income** before taxes and deductions for each employed household member.

| Name of Employed Household Member | Employer Name & Address | Amount Earned | How often? Weekly/Monthly/Annually |
|---|---|---|---|
| | | | |
| | | | |

6. **Other Income not from an employer.**

| Type of Income | Family Member Receiving Income | Amount | How often? Weekly/Monthly/Annually |
|---|---|---|---|
| Social Security | | | |
| Railroad Retirement | | | |
| Veterans' Benefits | | | |
| Retirement Funds | | | |
| Annuities | | | |
| Pensions | | | |
| Child Support | | | |
| Alimony | | | |
| Unemployment | | | |
| Workers Compensation | | | |
| Rental Income | | | |
| Trust Income | | | |
| Disability | | | |
| Farm or Self-Employment | | | |
| Dividend Income | | | |
| Bank Account Income | | | |
| Other Income, please specify: | | | |

7. **Liquid Assets**

A. Individual Assets: _____

B. Family Assets: _____

C. Assets Include:

1) Cash _____

2) Savings Accounts _____

3) Checking Accounts _____

4) Certificates of Deposits/I.R.A. _____

5) Equity in Real Estate (other than primary residence) _____

6) Other Assets (Treasury Bills, negotiable paper, Corporate stocks and bonds _____

7) **Total** _____

8. **Other Assets** – If you own any of the following items, please list the type and approximate value.

| | Make | Year | Approximate Value | Loan Balance |
|---|---|---|---|---|
| Home | N/A | | | |
| Automobile | | | | |
| Additional vehicle | | | | |
| Additional vehicle | | | | |
| Other property | | | | |
| | | | Totals: $ _____ | $ _____ |

9. Living Expenses. Fill in standard living expenses shown below.

| Payment Type | Recipient Name/Relationship | Amount Paid | How often? Weekly/Monthly/Annually |
|---|---|---|---|
| House Rental/Payment | | | |
| Gas/Electricity/Water | | | |
| Food Expense | | | |
| Other – List Details | | | |

10. **Other Expenses.** Fill in this section if you or anyone in Section 3 is required to make payments for alimony, child support, or personal needs allowance for a family member in a nursing home.

| Payment Type | Recipient Name/Relationship | Amount Paid | How often? Weekly/Monthly/Annually |
|---|---|---|---|
| Health Insurance | | | |
| Alimony | | | |
| Child Support | | | |
| Personal Needs Allowance | | | |

11. **Other Insurance.** Uncompensated Care is available for such things as your co-payments and deductibles even if you have other health insurance.

a. Are you covered under any health insurance program? Yes ___ No ___ If yes:

| Policy Holder (Name) | Insurance Company | Policy number |
|---|---|---|
| | | |
| | | |
| | | |

b. Are you seeking financial assistance because of a work-related accident or injury? Yes ___ No ___

c. Are you seeking financial assistance because of a car accident? Yes ___ No ___

d. Are you a student? Yes ___ No ___ If yes, are you full time? ___ Part time? ___

e. Do you have an application pending for any of these programs? (Check all that apply)
Medicaid ___ Medicare ___

f. Are you currently approved for financial assistance at another hospital or community health center? Yes ___ No ___ If yes, where? _____

12. **Medical Bills.** Total amount of medical bills is $_____

13. **Assignment of Rights.** Read this section carefully and sign.

I agree to tell this facility about changes to my family status including family size, income and insurance coverage that could change my eligibility for financial assistance.

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) that may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

I understand that this facility cannot share confidential information with any state or federal agency without my prior approval.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Authorized Representative Date

If you have questions about this application, contact Patient Financial Services at (406) 345-3354. Mail your completed application to:

Glendive Medical Center
Financial Assistance
202 Prospect Drive
Glendive, MT 59330

# Addendum B

**Documentation Checklist:**

- ❑ A letter of denial from Medicaid or copies of the Medicaid Card(s)
- ❑ Pay stubs or a letter from your employer as proof of income for the twenty-six week period prior to date of application. A form letter can be provided.
- ❑ Most recent tax return
- ❑ A Benefit Letter from Social Security stating the monthly amount as of date of application.
- ❑ Proof of income from any and all sources: support payments, welfare, unemployment, pension, stock dividends, and child support payments. Any other income, which helps with daily living, must be provided.
- ❑ Proof of assets: Checking and Savings account statements or a printout from the bank, which covers the date of application.
- ❑ Letter from the person supporting you, explaining the situation including their relationship to you, address, length and type of support they provide. A form letter can be provided.
- ❑ Two (2) forms of identification (ID) for the patient, one (1) form of ID for all other family members (i.e. Driver's License, Birth Certificate, and Social Security Card).
- ❑ Other _____

Please provide copies of all requested documents. **Do not send originals through the mail.** If you do not have access to a copier you can bring all the documents to the office and a Financial Counselor will make the copies for you.

If you have any questions, please do not hesitate to call the Business Office, (406) 345-3350.

Glendive Medical Center

# RELEASE OF INFORMATION

Date: _____

I hereby authorize you to release Employment, Insurance, Income, Bank Account balances, etc., to Glendive Medical Center (GMC). This information will assist me to apply for financial assistance with my hospital bills.

I am aware that this authorization will expire one (1) year from my dated signature.

_____ _____

Patient Signature Date