4a. Financial Assistance Application Check List

(For those filling out entire form)

Please be sure that you have answered all the questions on the application and included copies of required documents.

- ☐ Did you and your spouse sign and date the application?
- ☐ Did you enclose your most recent tax returns (federal and state), all pages and schedules, including W-2s?
- ☐ If you did not enclose a copy of your tax returns, why? ____
- ☐ Did you enclose copies of your earnings statements for the last 3 months?
- ☐ Did you enclose copies of all award letters for unemployment, financial aid for college, or general assistance?
- ☐ Did you enclose a copy of your Social Security check or copy of award letter?

- ☐ Did you enclose a copy of each of your last three bank statements?
- ☐ Did you enclose a copy of each of your last three pension/investment account statements (savings, CDs, stocks, etc.)?
- ☐ Did you write a letter explaining your need for financial assistance?

4b. Release of Information Authorization for Financial Assistance

(For ALL Applicants)

I certify that the information I provided is true and correct to the best of my knowledge. I will cooperate to obtain assistance and pay Central Montana Medical Center (CMMC) any money I receive.

I will provide CMMC, or billing agent, with information about any other means to pay this bill such as Medicaid, Crime Victims Fund, automobile, or home insurance policies, etc. I will cooperate with CMMC, or billing agent, to apply and obtain assistance from any government agency that I am qualified to receive assistance from and will pay CMMC any money I receive relating to these medical services.

I authorize CMMC, or billing agent, to contact employers, financial institutions, state, and federal agencies, and other third parties to verify the information I have provided or to obtain additional information regarding my finances. I authorize any such entities to provide information to CMMC, or billing agent, about my current assets, liabilities, credit, and other information as reasonably requested.

I release Billings Clinic and its representatives from any and all liability connected with this release of information. Please check the name of the facilities where you have an outstanding balance to be considered with this application:

- ☐ Central Montana Medical Center, or billing

_____ _____
Signature of Applicant (Patient, Parent or Guardian) Date

_____ _____
Signature of Spouse Date

Mailing Address:
Billings Clinic
Attn: PFS Financial Assistance
PO Box 35100
Billings, MT 59107

REV 05/22

Our community. Our hospital.
CMMC
Central Montana Medical Center

Financial Assistance Application

Clinic Account # _____

Hospital Account # _____

You may apply for financial assistance for you and your family if you do not have health insurance or are concerned that you may be unable to pay for all or part of your health care services.
We will work with you to see if you qualify for other health insurance programs, interest-free payment plan options, long-term loans, or our Financial Assistance Program. If you qualify for financial assistance, some or all of your balances may be reduced for medically necessary services only. *CMMC, or billing agent, will determine if a service is medically necessary based on the CMMC* Financial Assistance Policy, available at www.cmmc.health/for-patients/billing-and-financial-assistance/ or by calling a Patient Financial Representative.

1a. Household Information

Applicant: _____

Spouse: _____

Address: _____
Number and Street

_____
City State Zip Code

Home Phone: (_____) _____

Cell Phone: (_____) _____

Occupation: (You) _____

Date of Birth: _____

Social Security No.: _____

Employer: _____

Employer Address: _____

Phone: (_____) _____

Occupation: (Spouse) _____

Date of Birth: _____

Social Security No.: _____

Employer: _____

Employer Address: _____

Phone: (_____) _____

Other members living in the household:
(Add more on another sheet of paper)

_____
First and Last Name
_____
Relationship
_____
Date of Birth

_____
First and Last Name
_____
Relationship
_____
Date of Birth

_____
First and Last Name
_____
Relationship
_____
Date of Birth

_____
First and Last Name
_____
Relationship
_____
Date of Birth

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

1b. Are you currently receiving benefits for any of the public assistance programs listed below? *If so, you may automatically qualify for Financial Assistance.*

Please provide proof with a current copy of confirmation of eligibility for one program (such as a letter of approval or copy of monthly coverage). Check the box for the program(s) you participate in:

- ☐ Supplemental Nutrition Assistance Program (SNAP), also called Food Stamps
- ☐ Women, Infants and Children programs (WIC)
- ☐ Subsidized/low income housing assistance
- ☐ Low Income Energy Assistance Program (LIEAP)
- ☐ State-funded low income prescription programs
- ☐ Homeless, or receiving care from homeless clinic

If you checked a box, skip to page 4 and sign part b. If not, go to page 2.

If you are not currently receiving benefits for any of the public assistance programs listed on page 1b, please complete the remainder of this form.

To be considered for financial assistance, you must supply the following:

- ☐ Completed and signed application form
- ☐ Copies of most recent year's tax returns (federal and state), all pages and schedules, including W-2s
- ☐ Copies of earnings statements for the applicant and his/her spouse for the last three (3) months (pay stubs, Social Security, unemployment, retirement, pensions, child support, federal student aid)
- ☐ One copy of each of your last three bank statements – all pages
- ☐ One copy of each of your last three pension/investment account statements (savings, CDs, stocks, etc.)
- ☐ Letter explaining your need for financial assistance

Without the above listed items, your application could be denied as incomplete.

Please return this signed application and the above listed items within four (4) weeks. We will notify you in writing of our decision within 45 days of receiving a complete application. You have the right to appeal our determination.

Income - List all monthly gross income	Applicant	Spouse	Other	Total
Gross wages from paycheck				
Farm or self employed				
Social Security/SSI/SSDI				
Unemployment compensation				
Workers compensation				
Alimony				
Child support				
Pension/retirement				
Income from dividends, interest, rent				
Education grants/loans				
Inheritance				
Oil and mineral royalties/land lease				
Native American income				
Income tax refunds: ☐ federal ☐ state				
Settlement income: ☐ worker's comp. ☐ bodily injury ☐ lawsuit ☐ other ☐ motor vehicle accident				
Other income (please explain) _____				
Total				

☐ If you are currently unemployed, when was your last day of work? _____

☐ Will you receive unemployment? Yes ____ No ____

☐ If you are temporarily out of work, do you expect to return to the same job? Yes____ No____

If so, when _____

Assets - Financial (*Accounts I Own*)	Current Balance	Financial Institution Holding Account
Checking account		
Savings account #1		
Savings account #2		
CDs/bonds		
Stock/mutual funds		
Retirement funds		
Other: (Please List)		
Total	A	

For internal use only

Total Assets A + B1

Total Liabilities B2 + C1

Total Monthly Payments B3 + C2 + D

Assets - Property (*Property I Own*)	Current Value of Property	Amount Owed on Property	Monthly Payment (if loan associated with property)
House			
Auto #1			
Auto #2			
Auto #3			
RV			
Boat			
Motorcycle/ATV			
Rental property			
Other: (Please List)			
Total	B1	B2	B3

Liabilities (*Balances I Owe*)	Current Balance of Loan	Monthly Payment
Bank or credit union loans		
Credit cards		
Department store cards		
Outstanding medical bills		
School loans		
Other: (Please List)		
Total	C1	C2

Monthly Expenses	Amount
Rent	
Groceries/household products	
Lights & heat	
Phone (cell & home)	
Water & sewer	
Gasoline	
Insurance (health, home, auto, life, renter's, etc.)	
Childcare	
Child support	
Clothing	
Entertainment including TV, internet, movies, etc.	
Prescriptions	
Other: (Please List)	
Total	D