



FINANCIAL ASSISTANCE APPLICATION

Questions? Use the QR code on the right or go to cmmc.health to access CMMC's Assistance Policy OR call Patient Financial Services (406)535-1457 or 1(800)332-7156, x2601. Interpreter Services/Language Line 1(833)703-0016



1) Household Information:

Applicant (First, Middle, Last): _____

Date of Birth: _____

Spouse/Partner(First, Middle, Last: _____

Date of Birth: _____

Address: _____

Phone: _____

City, State, Zip: _____

Cell: _____

2) Other Household Members:

Name (First, Last): _____

Date of Birth: _____

Relationship to Applicant: _____

*More members can be listed on an additional page.

3) Check all CMMC locations you've received services from:

☐ Hospital

☐ DME

☐ Clinic

☐ Home Health

4) Public Assistance Benefits:

Are you currently receiving benefits from any of the following programs? If so, you may automatically qualify for 100% financial assistance. Please check all that apply.

Include documentation of your confirmation/eligibility in the following program(s) with your application:

☐ SNAP - Supplemental Nutrition Assistance Program

☐ WIC - Women, Infants, & Children Supplemental Nutrition Program

☐ Subsidized/Low Income Housing or Rental Assistance

☐ Low Income Energy Assistance Program (LIEAP)

☐ Low Income Prescription Programs

☐ Homeless or receiving care from a homeless shelter, clinic, or center

*If you checked any boxes above, skip to section 8.

5) Retired/Social Security Applicants:

Does your household have any other income sources besides social security and/or disability?

☐ Yes - continue to next section

☐ No - skip to section 8.

6) Employment Status:

Income Source	Applicant	Spouse	Required Documents
Employer Name & Length of Employment			Last 3 months of paystubs
Length of Unemployment			Unemployment award letter
Self-Employment (Type of self-employment)			Current YTD profit/loss statement
Retirement (S.S. IRA's, pension, etc.)			1099s
Length of Disability			Disability award letter from govt and/or private insurer
Student-school enrolled			N/A
Other Income-(rental income, interest, dividends, etc.)			Federal tax return

Required documentation for all applicants:

- 1) Copy of previous year's federal tax return, including all supporting schedules
- 2) Copy of most recent statements, including checking, savings, or any investment accounts
- 3) In event that you do not have requires documents; a letter of explanation must be submitted.

****Your financial assistance application will not be processed until all required documents are received****

7) Health Insurance Information:

☐ I have health insurance - Company/Plan Name:

Applicant: _____ Spouse/Partner: _____

☐ Health insurance is available to me, but I have declines or opted out. Reason:

Applicant: _____ Spouse/Partner: _____

☐ Payment is available to Applicant or Spouse/Partner through Health Share

☐ Other: _____

8) Release of Information and Attestation for Financial Assistance:

I certify that the information I have provided is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services provided by Central Montana Medical Center and its affiliated entities. I give permission to Central Montana Medical Center and its affiliated entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Central Montana Medical Center and its affiliates and representatives to investigate the information contained herein.

Signature of Applicant (Patient, Parent, or Guardian):

Date:

Signature of Spouse/Partner:

Date:

Please mail your application and documents to:

Central Montana Medical Center
408 Wendell Ave
Lewistown, MT 59457

Questions? Call Patient Financial Representatives: (406)535-1457 or 1(800)332-7156, ext. 2601