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. ***Elective services are excluded from this program.***

For services provided by:

- Frances Mahon Deaconess Hospital
- Glasgow Clinic Primary Care
- Glasgow Clinic Specialty Care

FRANCES MAHON DEACONESS HOSPITAL

Payment Options

At Frances Mahon Deaconess Hospital, we understand that medical bills can arise unexpectedly. To assist with these expenses, please review the options below.
Questions? Please call (406) 228-3633 or (406) 228-3620.

Financial Assistance

Financial assistance provides a discount on your bill based on your income and assets, minus any debts. To apply, please complete this form and submit it along with your proof of income. To see if you may qualify, refer to the chart on the right. Locate your family size in the left-hand column and look across to find where your total income falls. The exact amount of your discount may also be influenced by the value of your assets after debts are subtracted.

Annual Income

Family Size	Discount						Scale effective 2/3/2025	
	100%	90%	80%	70%	60%	50%	40%	30%
1	$ 31,300	$ 33,491	$ 35,839	$ 38,030	$ 40,221	$ 42,412	$ 44,759	$ 46,950
2	$ 42,300	$ 45,261	$ 48,434	$ 51,395	$ 54,356	$ 57,317	$ 60,489	$ 63,450
3	$ 53,300	$ 57,031	$ 61,029	$ 64,760	$ 68,490	$ 72,222	$ 46,219	$ 79,950
4	$ 64,300	$ 68,801	$ 73,624	$ 78,125	$ 82,626	$ 87,127	$ 91,949	$ 96,450
5	$ 75,300	$ 80,571	$ 86,219	$ 91,490	$ 96,761	$ 102,032	$ 107,679	$ 112,950
6	$ 86,300	$ 92,341	$ 98,814	$ 104,855	$ 110,896	$ 116,937	$ 123,409	$ 129,450
7	$ 97,300	$ 104,111	$ 111,409	$ 118,220	$ 125,031	$ 131,842	139*139	$ 145,950
8	$ 108,300	$ 115,881	$ 124,004	$ 131,585	$ 139,166	$ 146,747	$ 154,869	$ 162,450
9	$ 119,300	$ 127,651	$ 136,599	$ 144,950	$ 153,301	$ 161,652	$ 170,599	$ 178,950

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.

Finished Application

Return application & proof of income to:
FMDH Financial Counselor's Office
621 3rd St S
Glasgow, MT 59230

Application Checklist

☐ **Proof of Income Requirements**

- **Recent Paystubs or Monthly Income Documentation**: Provide paystubs or other documentation for all sources of monthly income from the past 90 days. This may include Social Security benefits, pension payments, etc.
- **Complete Tax Return(s)**: Submit a full copy of your most recent tax return, including all schedules. If you do not file taxes, please provide 3 months of current bank statements for all accounts.
- **Dependent Tax Return**: If you are claimed as a dependent on someone else's tax return, please include a copy of that return as well.
- **Additional Financial Information**: Provide any other financial documents necessary to verify income, such as statements used for operating notes.

☐ Fill in all fields, front and back.
☐ Sign & date application.
☐ Return within 10 days.

FMDH 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

Employer: _____ How many years/months? _____

Spouse Employer: _____ How many years/months? _____

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

Dependents (please list first & last name):

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Assets & Debts

	Estimated Value:	Amount Owing:
Home (if owned):		

Vehicles:

	Estimated Value:	Amount Owing:
Year: _____ Model: _____		
Year: _____ Model: _____		
Year: _____ Model: _____		

RV/Boat/Motorcycle:

	Estimated Value:	Amount Owing:
Year: _____ Model: _____		
Year: _____ Model: _____		

Other Loans (Student, Operating, 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: $_____

Certification

This 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