



No one will be denied access to medically necessary services based on inability to pay.

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 will also depend on the value of your assets minus your debts.

Annual Income

Family Size	Discount							
	100%	90%	80%	70%	60%	50%	40%	30%
1	\$17,486	\$18,735	\$19,984	\$21,233	\$22,482	\$23,731	\$24,980	\$29,976
2	\$23,674	\$25,365	\$27,056	\$28,747	\$30,438	\$32,129	\$33,820	\$40,584
3	\$29,862	\$31,995	\$34,128	\$36,261	\$38,394	\$40,527	\$42,660	\$51,192
4	\$36,050	\$38,625	\$41,200	\$43,775	\$46,350	\$48,925	\$51,500	\$61,800
5	\$42,238	\$45,255	\$48,272	\$51,289	\$54,306	\$57,323	\$60,340	\$72,408
6	\$48,426	\$51,885	\$55,344	\$58,803	\$62,262	\$65,721	\$69,180	\$83,016
7	\$54,614	\$58,515	\$62,416	\$66,317	\$70,218	\$74,119	\$78,020	\$93,624
8	\$60,802	\$65,145	\$69,488	\$73,831	\$78,174	\$82,517	\$86,860	\$104,232
9	\$66,990	\$71,775	\$76,560	\$81,345	\$86,130	\$90,915	\$95,700	\$114,840

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

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.

Print form

Fill in all fields, pages 2-4

Sign and date application

Return within 10 days

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.

Financial Assistance & Extended Payment Plan Application

All information relating to this application will be kept confidential.

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 Owning
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 \$ _____

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 information about the Healthy Montana Kids (HMK) program?

Yes or No (Please circle one)

Financial Assistance & Extended Payment Plan Application (continued)

Monthly Income (Proof of Income Required)

Employment (Gross Wages) \$ _____
 Part-Time Job (Gross Wages) \$ _____
 Social Security \$ _____
 Social Security Disability \$ _____
 Disability Pension \$ _____
 Veteran Pension \$ _____
 Retirement (all sources) \$ _____
 Unemployment \$ _____
 Workers Compensation \$ _____
 Union Benefits \$ _____
 Inheritance \$ _____
 Public Assistance (TANF) \$ _____
 SNAP (Food Stamps) \$ _____
 Alimony/Child Support \$ _____
 Rents/Royalties \$ _____
 Savings Interest \$ _____
 Investment Income \$ _____
 Other _____ \$ _____
 Total \$ _____

If you are claiming no income, how are you paying for living expenses?

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 Expenses \$ _____

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 Accounting Office.

Additional Information

Please provide any additional information that you would like to be considered as part of your applications: