

# Financial Assistance Application

FRANCES MAHON  
DEACONESS HOSPITAL

**For Services Provided By:**  
Frances Mahon Deaconess Hospital;  
Glasgow Clinic Primary Care; Glasgow Clinic Specialty Care

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.

Family Size	Discount							
	100%	90%	80%	70%	60%	50%	40%	30%
1	\$17,864	\$19,140	\$20,416	\$21,692	\$22,968	\$24,244	\$25,520	\$30,624
2	\$24,136	\$25,860	\$27,584	\$29,308	\$31,032	\$32,756	\$34,480	\$41,376
3	\$30,408	\$32,580	\$34,752	\$36,924	\$39,096	\$41,268	\$43,440	\$52,128
4	\$36,680	\$39,300	\$41,920	\$44,540	\$47,160	\$49,780	\$52,400	\$62,880
5	\$42,952	\$46,020	\$49,088	\$52,156	\$55,224	\$58,292	\$61,360	\$73,632
6	\$49,224	\$52,740	\$56,256	\$59,772	\$63,288	\$66,804	\$70,320	\$84,384
7	\$55,496	\$59,460	\$63,424	\$67,388	\$71,352	\$75,316	\$79,280	\$95,136
8	\$61,768	\$66,180	\$70,592	\$75,004	\$79,416	\$83,828	\$88,240	\$105,888
9	\$67,956	\$72,810	\$77,664	\$82,518	\$87,372	\$92,226	\$97,080	\$116,496

**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](http://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: