This Financial Assistance Application is being provided to you for completion so that we can determine if you qualify for our Financial Assistance Program.

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ✓ A copy of a photo ID (state driver's license/state ID) or other identification documents (Social Security card, alien registry card, birth certificate, baptismal or marriage certificate, passport, visa, employee ID card, etc.).
- ✓ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ✓ Last two weeks of paystubs with year to date totals, or last two months of paystubs without year to date totals (if paid in cash without paystubs, provide written verification from employer).
- ✓ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, wage and earning statement from Social Security office
- ✓ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter, a copy of your monthly Social Security check, or copies of bank statements from three months prior showing direct deposit of the Social Security benefit.
- ✓ Copies of bank statements for checking, savings, certificates of deposit, etc. for the last two months.
- ✓ If you are a student, a list of the current semester's credits/classes and a copy of your student ID.

- ☞ NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.
- ☞ NOTE: Where parents of a minor patient are divorced or separated but share responsibility for the minor's medical care, each parent must complete a separate application.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided

FINANCIAL ASSISTANCE APPLICATION

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

I. PERSONAL INFORMATION

Personal information of applicant (or parent, if applicant is a minor):

Name _____ Date of Birth _____
Last First MI

Address _____
Street City State Zip Code

Living at Address Since _____ Phone # (_____) _____ Social Security # _____

Marital Status: Single _____ Married _____ Divorced _____ Widow _____

Spouse's Name _____ Spouse's Social Security # _____ Date of Birth _____

List family members (including parents, patient, and natural or adoptive siblings) living at above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

II. INSURANCE INFORMATION

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan:		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Veteran's Benefits? (Y/N)		

III. EMPLOYMENT AND INCOME INFORMATION

Employment information of applicant (or parent, if applicant is a minor):

Employer _____ Unemployed? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position _____ Date of Hire _____

Student (Y/N)_____ Name of School_____ Number of Credits This Semester _____

Employment information of Spouse (if applicable):

Spouse's Employer _____ Unemployed ? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position_____ Date of Hire _____

Student (Y/N)_____ Name of School_____ Number of Credits This semester _____

IV. CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Phillips County Hospital, and I authorize Phillips County Hospital to contact third parties to verify the accuracy of the information I have provided. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature _____ Date of Request_____

Your completed application and supporting documentation may be submitted by:

- Hand-delivering to Susan Bibbs, Director of Revenue Services or to one of the PCH Business Office personnel at either:
  - 311 South 8th Ave East, Malta, MT 59538
- Mailing to Phillips County Hospital, ATTN – Susan Bibbs, Box 640, Malta, MT 59538

**** To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application *****

Applicants will be notified within 15 business days after submission of a complete application with all required