DUE BY:

383 North 17th Ave | Forsyth, MT 59327 | (406) 346-2761

PATIENT FINANCIAL ASSISTANCE APPLICATION

PLEASE SIGN AND DATE LAST PAGE **[ ] Pre-Determination**

#1 Responsible Party

Last Name | First Name | Middle Name

Address | City | State | Zip Code

Social Security | Date of Birth | Age

Home Phone | Cell Phone

Employer Name | Years Employed | Work Phone

[ ] Single [ ] Married [ ] Legally Separated [ ] Divorced [ ] Widow/Widower

#2 Spouse or Significant Other

Last Name | First Name | Middle Name

Address (if different from Patients) | City | State | Zip Code

Social Security | Date of Birth | Age

Home Phone | Cell Phone

Employer Name | Years Employed | Work Phone

#3 Dependents

Number of legal dependents _____ Ages of legal dependents _____

#4 Insurance Information

Does anyone in the household have health insurance? [ ] Yes [ ] No

Insured Name | Health Ins. Name | Policy number

#5 Household Monthly Gross Income

	Responsible Party	Spouse
Employment **(Gross Earnings)**	$	$
Self Employment *Business Type_____	$	$
Social Security	$	$
Real Estate Rental Income	$	$
Unemployment- Date Ended _____	$	$
Disability	$	$
Workmen's Compensation	$	$
Child Support	$	$
Alimony	$	$
Military Income	$	$
Food Stamps	$	$
Other	$	$
TOTAL	$	$

Use additional paper to include any other household members incomes not listed

#6 Savings and Investments

☐ I do not have a checking account
☐ I do not have a savings account

	Responsible Party	Spouse
Checking Account Balance	$	$
Savings Account Balance	$	$
Retirement	$	$
CD/IRA/403b/401k/Annuities/IRA's	$	$
Stocks/Bonds/Interest/Life Ins./Land	$	$
Other Savings and Investments _____	$	$
TOTAL	$	$

Use additional paper to include any other household members savings or investments not listed

#9 Other Comments

#10 Assignment of Rights

I understand that proof of income (see Financial Assistance Checklist) is required to process my application. I also understand that more information may be requested before my eligibility can be determined.

I hereby acknowledge that the information listed on this application is true and correct. If any information given proves to be untrue or is withheld I understand RHCC may take whatever action is appropriate. This action may include denial of this application up to and including denial of all future applications.

Signature	Date	ND (If joint	Signature	Date

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved By: _____

Date Approved: _____

Verification Checklist

Identification/Address: Driver's license, utility bill, employment ID, or other	Yes	No
Income: Prior year tax return, three most recent pay stubs, or other	Yes	No
Insurance: Insurance Cards	Yes	No