Bitterroot Health Daly Hospital
1200 Westwood Drive
Hamilton, Montana 59840
(406) 363-2211
www.bitterroothealth.org

Financial Assistance Program

Personal Financial Statement *(Confidential)*

****In order for MDMH to consider your application, all sections of the application must be complete****

I authorize the access and use of any and all information stored with Bitterroot Health Daly Hospital, including my protected health information (PHI) and personal financial information by the Bitterroot Health Daly Hospital Financial Assistance Committee. I understand that this information may be used in the decision making process regarding my qualification for financial assistance. In addition, your signature also authorizes Bitterroot Health Daly Hospital and Daly Foundation to verify information provided in this financial statement and to obtain a Credit Report.

Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Name:	SSN:	DOB:
Spouse's Name:	SSN:	DOB:
Mailing Address:	City/State:	Zip Code:
Physical Address:	City/State:	Zip Code:
Daytime Telephone #	Evening Telephone #	

Applicants Employer:	Position:	Date of Hire:
Average hours worked per week:	If unemployed, last date worked:	
If unemployed and/or not working full-time (32-40 hours per week), please explain why:		
Spouse's Employer:	Position:	Date of Hire:
Average hours worked per week:	If unemployed, last date worked:	
If unemployed and/or not working full-time (32-40 hours per week), please explain why:		

Number of Dependents:	Ages:
Name of Dependents (First & Last Name): ***MONTANA RESIDENTS: If you are within income guidelines for Healthy Montana Kids, all children must have health insurance coverage.***	
Are you covered by any insurance? (Check one box) Yes ☐ No ☐	
If uninsured, have you applied for insurance through healthcare.gov (Montana Healthcare Exchange)? Yes ☐ No ☐	
If no, why?	
Have you applied for Medicaid benefits or have you been screened for Medicaid benefits? (*Required for this application process if you are uninsured*) Yes ☐ No ☐	

Date Received: _____

GROSS MONTHLY INCOME	(BEFORE TAXES AND DEDUCTIONS)	
Source	**Self**	**Spouse**
Employment	$	$
Commissions/Bonuses/Tips	$	$
Unemployment/Workman's Comp	$	$
SSI or SSDI	$	$
Child Support	$	$
Retirement/Pension	$	$
Other (describe)	$	$
Total *(before taxes and deductions)*		

ASSETS	
CASH ON HAND	**$**
CHECKING ACCOUNT BALANCE *Provide current statement(s) showing value/balances for all accounts.*	**$**
SAVINGS ACCOUNT BALANCE *Provide current statement(s) showing value/balances for all accounts.*	**$**
STOCKS/BONDS/IRA/RETIREMENT/ETC. *Provide statement(s) showing value/balances.*	**$**
CASH VALUE OF LIFE INSURANCE	**$**
AUTO 1 **Year/Make:** **Model:**	**Current Value: $**
AUTO 2 **Year/Make:** **Model:**	**Current Value: $**
HOME/PROPERTY **Purchase Date: ___/____/____**	**Purchase Price: $** **Current Value: $**
OTHER PROPERTY (DESCRIBE)	**Current Value: $**
RECREATIONAL MERCHANDISE (DESCRIBE)	**Current Value: $**
OTHER ASSETS (DESCRIBE)	**Current Value: $**

Please Initial _____

EXPENSES / LIABILITIES	MONTHLY PAYMENTS	ACCOUNT BALANCE
Mortgage/Rent *(If no mortgage or rent expense, please explain why)*	**$**	**$**
Food **Do you receive SNAP benefits?**	**$** **YES / NO (circle one)**	**$** **If yes, amount per month $_____**
Utilities	**$**	**$**
Prescriptions	**$**	**$**
Insurance Health **Auto** **Other (specify)**	**$** **$** **$**	**$** **$** **$**
Auto Loan 1	**$**	**$**
Auto Loan 2	**$**	**$**
Telephone Home **Cell**	**$** **$**	**$** **$**
TV/Cable/Internet	**$**	**$**
Personal Loan (specify)	**$**	**$**
Other expenses (specify)	**$**	**$**
MEDICAL (LIST EACH)	**MONTHLY PAYMENTS**	**ACCOUNT BALANCE**
MDMH	**$**	**$**
	$	**$**
	$	**$**
	$	**$**
CREDIT CARDS (LIST EACH)	**MONTHLY PAYMENTS**	**ACCOUNT BALANCE**
	$	**$**
	$	**$**
	$	**$**
	$	**$**
CALCULATE	**TOTAL Monthly Payments**	**TOTAL Account Balance**
Total Expenses / Liabilities	**$**	**$**

Please Initial _____

ADDITIONAL INFORMATION

By filling out this financial assistance application you are indicating that you are unable to meet the Hospital's payment requirements for your account(s). In some cases we are able to consider reduced payments and/or balance reductions.

Please indicate what type of financial assistance you are applying for (check one):

☐ Reduced Monthly Payment or ☐ Reduction of Balance Owed

If you reported zero income please *describe in detail*

- How you pay the expenses listed on the financial assistance application *and* all other daily living expenses, and
- Why you are not working and your efforts in searching for employment.

You may use the back side of this form if additional space is needed for explanation.

If someone assists with your living expenses, *provide documentation for the amounts received*.

If you did not file a Federal Tax Return, please explain why.

If total expenses exceed income reported, please describe how expenses are met.

REQUIRED DOCUMENTATION CHECKLIST

- ☐ Completed financial assistance application
- ☐ Complete copy of *most current* Federal tax return **(including schedules and attachments)**
- ☐ Complete & detailed copy of *most current* monthly statement(s) for all banking and savings accounts
- ☐ Current copy of statement(s) for all Stocks/Bonds/IRA/Retirement/Etc.
- ☐ Year-to-date proof of **ALL** income (current pay stub(s) that shows total gross income for previous 3 months and documentation for all other types of income such as unemployment, child support, social security, pension, disability, etc.)
- ☐ Documentation regarding Medicaid denial or approval (uninsured patients only)

Applications without complete and required documentation will be returned.

Please return your Financial Assistance Application in a timely manner. The financial assistance committee meets once per month. Normal billing and collections will continue through the financial assistance application process. If you need help filling out the application or have questions please call the Patient Financial Service Rep at (406) 375-4444.

Return completed application to:
Bitterroot Health - Daly Hospital
ATTN: PATIENT ACCOUNTS
1200 Westwood Drive
Hamilton, MT 59840