

Financial Assistance

To be considered for financial assistance you **must provide** the following:

1. The completed and signed Financial Questionnaire
2. Copy of your **most recent bank statement** (Showing balance and activity for at least 60days).
3. Copy of your previous year's **Federal Tax Return**
4. Copies of your **2 most recent pay stubs** to validate household income. (If you are self employed, provide copies of **three months Profit and Loss Statements**).
5. Supporting documentation of all forms of income. For example; public assistance award or denial letters, alimony court orders.
6. Verification of **Investment Value(s)**: Mutual Funds, Certificate of Deposits, Savings. (The amount of monthly income (if any) from specified retirement or pension plans (e.g. 401K, 403b, IRA, Roth IRA), etc.)
7. **If you are claiming no income** or there has been a recent change in your financial situation you **must** include a letter of explanation. If someone else is paying for your food and shelter please include a letter of explanation from them. **Also**, please verify that you have no source of income and how long it has been since you have not had a source of income. Examples of verification may include but are not limited to: Current Tax Return, letter from a professional business, bank statements showing no deposits/withdrawals, Medicaid determination letter, etc.
8. Mail questionnaire and supporting documentation to:
St. Joseph Medical
Attn: Shirley Schliep
PO Box 1010
Polson, MT 59860

Applications may also be dropped off in Main Admissions at the hospital.

Applications **must** be returned within **14 business days** or **requests may be denied**. Please note that if financial assistance is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical groups, hospitals, or physicians groups unless they specifically agree to accept it.

**PLEASE CONTACT THE OTHER MEDICAL GROUPS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.
(I.E. PHYSICIAN BILLING, ETC.)**

When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have questions or need assistance please contact Customer Service at 406-883-5377.

SJMC Financial Assistance Application

Date ____ / ____ / ____

First Name _____ Middle Initial _____ Last Name _____

Street Address _____ Apt # ____ City _____ State _____ Zip Code _____

Home Phone Number _____ Alternate Phone Number _____

Patient Name (First, Middle, Last) _____

Service Date (s) _____

Account Number(s) _____

Total Balance Due \$ _____

Family Size

Total number of persons living in household: _____

	Name	Relationship	DOB	Citizen Yes/No
Guarantor/Patient				
Spouse				
Child				
Child				
Child				
Child				
Other Family Member				
Non-Citizens				
United States Sponsor				

Income (Monthly)

	Person 1	Person 2	Person 3/ Sponsor	Grand Total
Gross Wages/Salary	\$	\$	\$	\$
Employer Name	\$	\$	\$	\$
Phone Number	\$	\$	\$	\$
Start Date	\$	\$	\$	\$
Termination Date	\$	\$	\$	\$
Unemployment	\$	\$	\$	\$
Public Assistance (Cash)	\$	\$	\$	\$
Social Security	\$	\$	\$	\$
Retirement or Pension Income	\$	\$	\$	\$
VA Benefits	\$	\$	\$	\$
Workers Compensation	\$	\$	\$	\$
Income Producing Property (Rent)	\$	\$	\$	\$
(Child Support)	\$	\$	\$	\$
Other	\$	\$	\$	\$
Other	\$	\$	\$	\$
Combined Total Monthly Income:	\$	\$	\$	\$

Checking/Savings Accounts, Investments, and Insurance

Does your household have a checking account?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Balance	\$
Does your household have a savings account?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Balance	\$
Does your household have any Investments, Money Market, CD's, etc.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Value	\$
Are you drawing monthly income from Investments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount per month	\$
Have you applied for Medicaid in the past 90 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, what was the determination: (Please provide copy of award letter)	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied		
Do you have Medical Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Insurance Company Name:				
Policy #				
Group #				
Phone #				
Address:				
List any other properties you own <u>other than</u> your primary residence.	Type of Property (house, condo, etc)	Tax Assessed Value	Outstanding Mortgage	
		\$	\$	
		\$	\$	

I understand that the information provided by me is subject to verification by the hospital. I understand that any false information provided by me will result in a denial of any hospital financial assistance. Financial assistance is available only after all other forms of reimbursement (health insurance, Medicaid, or third party insurance) have been exhausted.

Signature: _____

Date: _____