PO BOX 705, 315 W. MADISON
CHESTER, MT 59522
www.libertymedicalcenter.org

Financial Assistance Application

Liberty Medical Center is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance with our health system.

Enclosed with this letter, you will find the Financial Assistance Application. You must complete this application in full to receive consideration for financial assistance. If your financial situation meets the criteria set forth by Liberty Medical Center, part or all of your account balance may be forgiven.

The right to apply for financial assistance consideration begins on the date of service and extends through the 240th day after the first billing statement is sent to the patient or guarantor. However, patients and guarantors are encouraged to submit their Financial Assistance Application as soon as possible.

In order to process this application we require:

* **The enclosed form completed in its entirety**

* **Provide proof of all income (ie. the last 2 paystubs for each wage earner, SS, SSI, SSDI, Public Assistance, Retirement, Pension, VA Benefits, Unemployment Compensation, Workers Compensation, Child Support, Alimony or other)**

* **Copy of your most recent tax return including all applicable schedules**
  - **If self-employed, please include schedule C**
  - **If farmer please, include Schedule F**

* **If your most recent tax return is not available, then we need one of the following:**
  - **Social Security Awards Letter**
  - **Proof of non filing from the IRS**

* **Proof of Third Party Coverage Status or Eligibility (including Medicare or Medicaid)**

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes you current financial situation.

Once we have reviewed you application, we will notify you of our decision in writing within 30 days of receipt of a completed application. If you wish to discuss your account or have any questions, please contact Patient Financial Services at 406-759-5181 ext. 6508. Our business hours are Monday through Friday from 8:00 am to 5:00 pm.

Please respond to this request for information **within 30 days**. You can return the completed application to our office in person, via fax at 406-759-5799 or mail to Liberty Medical Center, PO Box 705, Chester, MT 59522.

Thank you for your business.

Sincerely,
Tracie Romanchuk
Patient Financial Assistance

Financial Assistance Application

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*FOR OFFICE USE ONLY	
Account Number:	
Date Sent:	
Return by:	

Applicant

Last Name	First Name	MI	Social Security #	Date of Birth
Address	City		State	Zip Code
Home Phone Number	Cell Phone Number		Work Phone Number	
Maritial Status ____Married ____Single ____Divorced ____Widowed				
Employer	Occupation	Hourly Wage	Hr Worked/Week	Years Employed

Spouse

Last Name	First Name	MI	Social Security #	Date of Birth
Home Phone Number	Cell Phone Number		Work Phone Number	
Employer	Occupation	Hourly Wage	Hr Worked/Week	Years Employed

Please list all dependents living in your household: **(Use an additional sheet if necessary)**

Last Name	First Name	MI	Date of Birth	Social Security #	Relationship to Applicant
1)					
2)					
3)					
4)					

***Required** **Income: Represents total cash receipts form all sources before taxes**

	Self Monthly Gross		Spouse Monthly Gross
Gross Employment Wages/Salary		Gross Employment Wages/Salary	
Part-Time Jobs		Part-Time Jobs	
Self-Employment Income		Self-Employment Income	
Social Security / Disability		Social Security / Disability	
Retirement (All Sources)		Retirement (All Sources)	
Veteran Pension		Veteran Pension	
Unemployment Compensation		Unemployment Compensation	
Workers Compensation		Workers Compensation	
Union Benefits		Union Benefits	
Child Support / Alimony		Child Support / Alimony	
TOTAL		**TOTAL**	
		TOTAL COMBINED MONTHLY GROSS INCOME	

How much of your LMC bill are you paying /or are you able to pay per month? _____

Additional Information:

Have you ever declared bankruptcy? _____ No _____ Yes Date Filed: _____ Date Discharged: _____

Type of Bankruptcy: _____ Chapter 7 _____ Chapter 13

Do you have any judgments or liens filed against you? _____ No _____ Yes

If yes, please provide date and reasons: _____

During the past 12 months, hve you ever received any benefits such as welfare payment, food stamps, Medicaid, emergency energy assistance, County Poor Relief, etc? _____ No _____ Yes (Please list below benefits received)

_____

MEDICAL BILLS:

What is the approximate amount of LMC bills you owe (include hospital and clinic)? _____

What is the approximate amount of other (non-LMC) medical bills you owe? _____

Primary Insuranace Coverage: _____ ID# _____

Secondary Insurance Coverage: _____ ID# _____

OTHER COMMENTS:

Please inform us of any additional information you would like us to consider with your application.

_____

_____

_____

***Optional**	**Monthly Expenses:**		
	Monthly Amounts		**Monthly Amounts**
House Payment		Electricity	
Rent		Heat	
Property Taxes		Water and Sewer	
Property Insurance		Garbage	
Vehicle Payment		Phone/Cell Phone	
Vehicle Insurance		Cable	
Transportation/Car Expense		Internet	
Bank Loans		Food	
Credit Cards		Child Care / Day Care	
Health/Dental Insurance		Child Support Expense	
Life Insurance		Other:	
Medications / Prescriptions		Other:	
		TOTAL MONTHLY EXPENSES	

Applicant Signatuare: _____ Date: _____

Spouse Signatuare: _____ Date: _____

FOR OFFICE USE ONLY: Approved _____ Denied _____

Comments _____

_____

Signature _____Date _____

Signature _____Date _____

Signature _____Date _____