



## Financial Assistance Application

PO BOX 705, 315 W. MADISON  
CHESTER, MT 59522  
[www.libertymedicalcenter.org](http://www.libertymedicalcenter.org)

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**
  - o **If self-employed, please include schedule C**
  - o **If farmer please, include Schedule F**
- \* **If your most recent tax return is not available, then we need one of the following:**
  - o **Social Security Awards Letter**
  - o **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. 5959. 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,  
Krista Cook  
Patient Financial Assistance



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## Financial Assistance Application

**\*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	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> 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 from 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	
<b>TOTAL</b>		<b>TOTAL</b>	
<b>TOTAL COMBINED MONTHLY GROSS INCOME</b>			

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 Insurance 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:	
<b>TOTAL MONTHLY EXPENSES</b>			

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_

Date: \_\_\_\_\_

FOR OFFICE USE ONLY: Approved \_\_\_\_\_ Denied \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_