BARRETT
HOSPITAL & HEALTHCARE
600 MT Highway 91 South · Dillon, MT 59725 · (406) 683-3000
www.barretthospital.org

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Complete this application in its entirety, include all supporting documentation, and contact a Personal Finance Advocate, before the deadline below, by calling 406-683-3034 or emailing fc@barretthospital.org to set an appointment to submit your application. Documentation requirements will vary based on individual situation(s). The minimum required documents are listed below. Applicants will be notified in writing if any additional document(s) will be required to complete their application along with the required return by date. Refer to the Financial Assistance Policy and appendix documents for additional program details.

FINANCIAL ASSISTANCE PROGRAM MINIMUM DOCUMENT REQUIREMENTS:

1 – Completed financial assistance application

2 – Proof of household income (Parent household income is also required if college student is being claimed on the parent's taxes) (If there are bills for minor children from split homes, household income is required for both parents. Parenting plans are a contract between the parents and are not binding for medically rendered services.)

All of the following documents are required:

- Most recent Income Tax return (Full return for State and Federal)
- Last months' pay stubs or signed and dated employer income verification statement. (This includes pensions and Veterans benefits.)

3 – Copies of all unpaid medical bills

4 - Value of assets: Savings and checking accounts, IRAs, CDs, Stocks, Etc. (include copies of bank statements)

5 – Any award or current letters from SNAP benefits, Social Security, SSI, or award letter from another facility that has granted charity

6 – Student aide, grants, loans, scholarships, student account summary, parental assistance, etc.

7 – Other _____

- **signed and dated letter of circumstance for extenuating circumstances and/or a signed and dated letter of explanation for any document that you are unable to provide)**

_____ _____

Name of BHHC representative **Date given to patient**

IF THE COMPLETED APPLICATION IS NOT RECEIVED BY THE DEADLINE WITH ALL REQUESTED DOCUMENTATION, ASSISTANCE WILL NOT BE CONSIDERED AND BALANCE(S) WILL BE SUBJECT TO COLLECTION AND CREDIT REPORTING IN 30 DAYS FROM THE APPLICATION DEADLINE.

Application Deadline:_____

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Financial Assistance Program Application

Please complete all of the information and return to:
Barrett Hospital & HealthCare
Personal Finance Advocate
600 Highway 91 South
Dillon, MT 59725

Name:	SSN:	DOB:
Spouses Name:	SSN:	DOB:
Address:		
Email Address:		
City:	State:	Zip Code:
Telephone Number:	Message Phone:	

Number of individuals residing in household (Please list first and last names)

Name	Relationship	Date Of Birth	Health Insurance?	Medicaid or Medicare?
	Self			

Income

Name	Employer Name/Address/Phone	Gross Monthly Income (before tax)
Self		$
		$
		$
		$
		$
		$

Do you or anyone in your household receive the following?

Source of Income	Family Member	Amount
SNAP Benefit (Food Stamps)		$
Other forms of Public Assistance		$
Farm or Self-Employed Income		$
Social Security		$
Social Security/ Supplemental (SSI)		$

Pensions/Retirement		$
Unemployment Compensation		$
Workers Compensation		$
Alimony		$
Child Support		$
AFDC (Aid for Dependent Children)		$
Military Income / Reserve Pay		$
Financial Assistance from another Hospital		$

Expenses

Monthly Expenses

Living Expenses	Monthly Payment
Housing Expenses (Mortgage/Rent)	$
Food	$
Utilities	$
Insurance	$
Auto/Transportation/Gas	$
Phone	$
Other	$

Bank Accounts

	Institution	Value

Cash on Hand		**$**
Savings		**$**
Personal Checking Account		**$**
Business Account		**$**

Assets

Home

		Value
Description	Balance $	$

Auto(s)

		Value
Year / Make	Model	$
Year / Make	Model	$

Other Property, Stocks, RV, Boat, Motorcycle, Livestock, or Trusts

		Value
Description	Balance $	$
Description	Balance $	$
Description	Balance $	$

Creditors (Credit cards, loans, collection agency accounts)

List Names	Current Balance	Monthly Payment
Medical/Hospital/Doctors/ Dentists/Pharmacy	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

	$	$

In some situations, your ability to qualify for financial assistance may be indefinite. In that case, you may be asked to visit with a personal finance advocate, so they can further review your financial situation. Additional documentation might be required. Periodic reapplication will be required based on change of circumstance and in accordance with the financial assistance policy.

I certify that the above information was given in good faith and, to the best of my knowledge, is true and correct. I give my consent for Barrett Hospital & HealthCare to verify the above information. 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: _____

Authorization for Disclosure of Protected Health Information

I authorize Barrett Hospital & HealthCare 600 Highway 91 South Dillon MT 59725 Tel. 406.683.3000 to release the financial assistance program letter of approved assistance to Intercity Radiology PC 925 Highland Blvd Ste. 1180 Bozeman MT 59715 Tel. 406.587.8631 for financial assistance consideration for imaging reading charges associated with Barrett Hospital & HealthCare. I understand that I may refuse this authorization and that my refusal to sign may affect my ability to obtain financial assistance from Intercity Radiology PC and I will be fully responsible for those balances.

Signature: _____ Date: _____