Roundup Memorial
Healthcare

COMMUNITY CARING PROGRAM - FINANCIAL ASSISTANCE

Date: _____ **Patient(s) Name/Acct #:** _____

Head of Household: _____ **Spouse:** _____

Address: _____

Telephone: ( ) _____ **(h)** ( ) _____ **(c)** ( ) _____ **(w)**

Date of birth: _____ **Social Security #:** _____

Employer _____ **Occupation:** _____

Health Insurance Plan(s): _____

 # Of Related Persons living in your household: _____
Please list all members living in the household:

Name (first & last name)	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently receiving benefits from any public assistance programs listed below: If so, you may automatically qualify for Financial Assistance. Please provide proof with a current copy of confirmation of eligibility for on program) such as a letter of approval or copy of monthly coverage). Please check below:

_____ **Supplemental Nutrition Assistance Program (SNAP), also called Food Stamps**
_____ **Women, Infants, and Children programs (WIC)**
_____ **Subsidized/low income housing assistance**
_____ **Low Income Energy Assistance Program (LIEAP)**
_____ **State-Funded low income prescription programs**
_____ **Homeless, or receiving care from a home less clinic**

** **If you checked above, skip to page 2 and sign Release of Information Authorization. If not, go to page 2 and complete application.**

Annual Household Income	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.	$ _____	$ _____	$_____	$_____
Farm or Self-Employment	$_____	$_____	$_____	$_____
Public Assistance, Food Stamps, etc.	$_____	$_____	$ _____	$ _____
Social Security/Supplemental Security(SSI)	$_____	$_____	$ _____	$ _____
Unemployment Compensation	$_____	$_____	$ _____	$ _____
Worker's Compensation	$_____	$_____	$ _____	$ _____
Alimony, Child support, Pensions	$_____	$_____	$ _____	$ _____
Income from dividends, interest, rent	$_____	$_____	$ _____	$ _____
Other Income (explain) _____	$ _____	$ _____	$ _____	$ _____
TOTAL INCOME	**$ _____**	**$ _____**	**$ _____**	**$ _____**

Your initials _____

Release of Information Authorization For Financial Assistance

I certify that the provided information is true and correct to the best of my knowledge.

I will exhaust all other possible resources for payment of my medical services such as private insurance, Medicaid, Medicare, Veterans Administrations or Crime Victims, etc. I will take any action reasonably necessary to obtain such assistance and will assign or pay to Roundup Memorial Healthcare the full amount recovered.

I authorize a representative of Roundup Memorial Healthcare to obtain personal, financial or medical information from any source deemed necessary to determine my eligibility for financial assistance. In so authorizing, I release Roundup Memorial Healthcare and its representatives from any or all liability connected with this release.

_____ _____ _____

Name (Print) Date Signature

Mailing Address:
Roundup Memorial Healthcare
Patient Account Services
P. O. Box 40
Roundup, MT 59072

Phone Numbers:
(406) 323-2301
(406) 323-3337
Fax: (406) 323-3002

VERIFICATION CHECKLIST (attach copies)	YES	
Identification/Address: Driver's license, Social security card or other		
Income: Prior year tax return, three most recent pay stubs, social security, unemployment, etc.		
Insurance: Insurance Card		
Medicaid: Application made or evidence of rejection		

OFFICE USE ONLY

AMOUNTS: Hospital $ _____ Clinic $ _____

Approved: _____% Disapproved:_____ Date: _____

PAR:_____ BOM: _____ CEO: _____