



Mountainview Medical Center
PO Box Q/16 W Main
White Sulphur Springs, MT 59645
(406) 547-3321

FINANCIAL ASSISTANCE APPLICATION

GUARANTOR/ACCOUNT # _____

Name: _____

Spouse: _____

SS#: ____-____-____ DOB: ____/____/____

SS#: ____-____-____ DOB: ____/____/____

Street Address: _____

Street Address: _____

Mailing Address: _____

Mailing Address: _____

City/State/Zip: _____

City/State/Zip: _____

Marital Status: Married ____ Divorced ____ Widowed ____ Single ____

Please provide the following information so we can contact you regarding this document.

Home # _____ Work # _____ Cell # _____ Message # _____

Please list the names, relationship, and age of dependents currently living in the home:

NAME	SSN	AGE	RELATIONSHIP

EMPLOYMENT HISTORY

PLEASE ATTACH A COPY OF YOUR SOCIAL SECURITY STATEMENT, THREE MOST RECENT PAY STUBS AND YOUR MOST CURRENT FEDERAL INCOME TAX RETURN FOR BOTH YOU AND YOUR SPOUSE.

Present Employer:

Spouse's Present Employer:

Name: _____

Name: _____

Phone #: _____

Phone #: _____

Position: _____

Position: _____

Start Date: _____

Start Date: _____

Wage \$: _____/hour Pay Dates: _____

Wage \$: _____/hour Pay Dates: _____

Gross Monthly Income \$ _____

Gross Monthly Income \$ _____

ADDITIONAL INCOME

Self:

Spouse:

Social Security Benefits \$ _____
Pension \$ _____
Child Support \$ _____
Student Financial Aid \$ _____
Bonuses \$ _____
Interest Income \$ _____
Disability \$ _____
Unemployment \$ _____
Worker's Compensation \$ _____
Alimony \$ _____

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Worker's Compensation \$ _____
Alimony \$ _____

TOTAL \$ _____

TOTAL \$ _____

Total Monthly Gross and Additional Income: \$ _____

Total Monthly Gross and Additional Income: \$ _____

BANK/CREDIT UNION INFORMATION

Self - Checking:

Spouse - Checking:

Bank Name: _____

Bank Name: _____

Checking Balance \$ _____

Checking Balance \$ _____

Self – Savings:

Spouse – Savings:

Bank Name: _____

Bank Name: _____

Savings Balance \$ _____

Savings Balance \$ _____

MONTHLY EXPENSES

Please provide verification where applicable

	Regular Monthly Payment	Amount Past Due
Mortgage/Rent	\$ _____	\$ _____
Groceries (Estimate)	\$ _____	\$ _____
Health/Life Insurance	\$ _____	\$ _____
Auto Insurance	\$ _____	\$ _____
Utilities (Lights, Water, etc)	\$ _____	\$ _____
Phone (Basic)	\$ _____	\$ _____
Cable	\$ _____	\$ _____
Child Care	\$ _____	\$ _____
Transportation (estimate)	\$ _____	\$ _____
Child Support	\$ _____	\$ _____
Hospital/Clinic	\$ _____	\$ _____
Pharmacy	\$ _____	\$ _____
Medicare Premium	\$ _____	\$ _____
Taxes (Property)	\$ _____	\$ _____
Alimony	\$ _____	\$ _____

Please bring a copy of Property Taxes

MORTGAGE INFORMATION

1ST Mortgage Company: _____

Current: Yes _____ No _____ If no, number of months behind: _____

Purchase Price \$ _____ Balance \$ _____ Equity \$ _____ Value \$ _____

2nd Mortgage Company: _____

Current: Yes _____ No _____ If no, number of months behind: _____

Purchase Price \$ _____ Balance \$ _____ Equity \$ _____ Value \$ _____

I acknowledge that the information given to Mountainview Medical Center on this financial statement is true and correct. I authorize Mountainview Medical Center to contact my employer(s) to verify my income.

Applicants Signature: _____ Date: _____

Spouses Signature: _____ Date: _____

IF NO PROOF OF INCOME OR TAX RETURN PROVIDED, YOUR FINANCIAL ASSISTANCE APPLICATION WILL BE DENIED.

Proof of Income includes: Social Security/Disability Benefits, Workers Compensation, Child Support Unemployment, Wage Earnings Statement (from Social Security Office), and pay stubs.

If you have any questions, please contact Patient Financial Services:

Brenda Nelson (406) 547-3323 ext124

FOR OFFICE USE ONLY

Total Annual Gross Income \$ _____

Family Size _____

Federal Poverty Level % _____

Approved _____ Denied/Reason _____

Comments

Approved By: _____ Date: _____