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:

Name: _____

Phone #: _____

Position: _____

Start Date: _____

Wage $: _____/hour Pay Dates: _____

Gross Monthly Income $ _____

Spouse's Present Employer:

Name: _____

Phone #: _____

Position: _____

Start Date: _____

Wage $: _____/hour Pay Dates: _____

Gross Monthly Income $ _____

ADDITIONAL INCOME

| Self: | | Spouse: | |
|---|---|---|---|
| Social Security Benefits | $_____ | Social Security Benefits | $_____ |
| Pension | $_____ | Pension | $_____ |
| Child Support | $_____ | Child Support | $_____ |
| Student Financial Aid | $_____ | Student Financial Aid | $_____ |
| Bonuses | $_____ | Bonuses | $_____ |
| Interest Income | $_____ | Interest Income | $_____ |
| Disability | $_____ | Disability | $_____ |
| Unemployment | $_____ | Unemployment | $_____ |
| Worker's Compensation | $_____ | Worker's Compensation | $_____ |
| Alimony | $_____ | Alimony | $_____ |
| TOTAL | $_____ | TOTAL | $_____ |
| Total Monthly Gross and Additional Income: | $_____ | Total Monthly Gross and Additional Income: | $_____ |

BANK/CREDIT UNION INFORMATION

Self – Checking:

Bank Name: _____

Checking Balance $ _____

Spouse – Checking:

Bank Name: _____

Checking Balance $ _____

Self – Savings:

Bank Name: _____

Savings Balance $ _____

Spouse – Savings:

Bank Name: _____

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 $ _____

OPEN ACCOUNTS

| CREDITOR | PHONE # | BALANCE | MONTHLY PAYMENT |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

LOANS
(Automobiles, Recreational Vehicles, ect.)

| Year | Make | Model | Owner(s) | License # | Balance | Value |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

COMMENTS

_____

_____

_____

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_____

_____

_____

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: _____

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

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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

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FOR OFFICE USE ONLY

Total Annual Gross Income $ _____

Family Size _____

Federal Poverty Level % _____

Approved _____ Denied/Reason _____

Comments

Approved By: _____ Date: _____