FINANCIAL ASSISTANCE APPLICATION
ST MARY'S HEALTH CENTER PATIENTS

ALL SPACES NEED TO BE COMPLETED FOR APPLICATION TO BE ACCEPTED.

Patient/Guarantor Information:______________________________ Phone#:________________

Address:_____________________________ City:__________________ State:____ Zip: ______

Do you have other health insurance? (Circle Response) Yes No   Are you on active disability? Yes No

If you have other health insurance please attach a copy of the insurance card(s) to this application.

IN ORDER TO PROCESS YOUR APPLICATION YOU MUST ATTEST TO YOUR TOTAL INCOME.
PLEASE SEND CURRENT W2S AND PROOF OF INCOME AND COPY OF LATEST TAX RETURNS.

You may be asked to provide documentation to support the income information attested to below. Please give the following information for the patient, spouse and all of the patient's children, natural or adoptive, under the age of 18, living in the home for which the patient is legally responsible.

INCOME TO INCLUDE ANY OF THE FOLLOWING:

Wages, Bonuses, Tips	Farm or Self Employment	Pensions	Public Assistance
Social Security	Workers Compensation	Strike Benefits	Unemployment Compensation
Alimony, Child Support	Military Allotments	Tax Returns	Interest, Dividends, Rents

NAME	DATE OF BIRTH	RELATIONSHIP TO YOU self, spouse, child	SOCIAL SECURITY NUMBER	SOURCE OF INCOME	GROSS MONTHLY INCOME AMT

Real Estate (EXCLUDING PRIMARY RESIDENCE)	Present Value
Stocks, Bonds, IRA & Mutual Funds	Value
Checking/Savings	Balance

If you list your income as $0 please provide information regarding your living situation/means of support on the lines below.

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This document is legal and binding. Your signature below attests, that to your knowledge, the information provided is current and accurate. **Must be signed and dated to be valid.**

Signature ____ Date _______________

FOR OFFICE USE ONLY
Financial Assistance Approved YES ______NO _______
Percent Approval ____________ Application Completed ____________
Approval Supervisor ___________________________ Date ___________
Approval Director _____________________________ Date ___________
Approval Chief Financial Officer _______________ Date ___________

MAIL APPLICATION TO:

St. Mary's Health Center
Patient Accts- Financial Assistance
1643 Lewis Ave. Ste. 203
Billings MT 59102

Rev 11/11/09

Questions? Please call: 866-799-4159