FRANCES MAHON
DEACONESS HOSPITAL

Financial Assistance Application

For Services Provided By:
Frances Mahon Deaconess Hospital;
Glasgow Clinic Primary Care; Glasgow Clinic Specialty Care

No one will be denied access to medically necessary services based on inability to pay.

Payment Options

At Frances Mahon Deaconess Hospital, we understand that medical bills may occur when you least expect them. To help with these bills, please see options below.

Please call (406)228-3633 or 228-3620.

Financial Assistance

Financial assistance is a discount on your bill, based on your income and assets minus debts. To apply, fill out this form and return with proof of income. To check if you may qualify, please refer to the chart on the right. Find your family size in the left hand column and look across to see where your total income falls. The actual amount of your discount will also depend on the value of your assets minus your debts.

Annual Income

Family Size	Discount							Scale effective 01/15/20
	100%	90%	80%	70%	60%	50%	40%	30%
1	$17,864	$19,140	$20,416	$21,692	$22,968	$24,244	$25,520	$30,624
2	$24,136	$25,860	$27,584	$39,308	$31,032	$32,756	$34,480	$41,376
3	$30,408	$32,580	$34,752	$36,924	$39,096	$41,268	$43,440	$52,128
4	$36,680	$39,300	$41,920	$44,540	$47,160	$49,780	$52,400	$62,880
5	$42,952	$46,020	$49,088	$52,156	$55,224	$58,292	$61,360	$73,632
6	$49,224	$52,740	$56,256	$59,772	$63,288	$66,804	$70,320	$84,384
7	$55,496	$59,460	$63,424	$67,388	$71,352	$75,316	$79,280	$95,136
8	$61,768	$66,180	$70,592	$75,004	$79,416	$83,828	$88,240	$105,888
9	$67,956	$72,810	$77,664	$82,518	$87,372	$92,226	$97,080	$116,496

Elective services are excluded from this program. Refer to the interest free payment plans for these services.

Application Checklist

☐ **Proof of Income**
- Paystubs or proof of other monthly income sources for the last 90 days. This could include social security income, pension benefits, etc.. (see Monthly Income Section)
- A complete copy of your most recent tax return(s) including all schedules.
- If you are claimed on another tax return, please provide that return as well.
- Any other information that may be necessary to qualify such as financial statements used for operating notes.

☐ **Print form**
☐ **Fill in all fields, pages 2-4**
☐ **Sign and date application**
☐ **Return within 10 days**

Interest Free Payment Plans

We offer a monthly payment plan for up to 12 months without an application. To extend payments beyond 12 months, please fill out this application.

Lump Sum Payment

We have smaller monthly payment plans that include a lump sum payment payable when an income tax refund or a farm payment is received.

Financial Assistance & Extended Payment Plan Application

All information relating to this application will be kept confidential.

Head of Household _____ Date of Birth _____ SS# _____

Spouse/Partner _____ Date of Birth _____ SS# _____

Street Address _____ City/State _____ Zip _____

Telephone _____ Marital Status: Married Single Divorced Widowed (circle one)

Employer _____ How many years/months? _____

Spouse Employer _____ How many years/months? _____

Disabled? No Yes (date) _____ Applied for Disability (date) _____

Dependents (please list first and last name):

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Assets and Debts

	Estimated Value	Amount Owing
Home (if owned):	_____	_____
Vehicles:		
Year _____ Model _____	_____	_____
Year _____ Model _____	_____	_____
Year _____ Model _____	_____	_____
RV/ Boat/Motorcycle:		
Year _____ Model _____	_____	_____
Year _____ Model _____	_____	_____

Checking Account Balance _____

Bank or Institution _____

Savings Account Balance _____

Bank or Institution _____

Investments (Please list any Stocks/Mutual Funds, Mineral Rights, IRAs, CDs, Rental Property, etc.)

1 _____ $ _____

2 _____ $ _____

3 _____ $ _____

4 _____ $ _____

Other Loans (Student Loans, Operating Loans, etc.):

Type	Amount Owed
_____	_____
_____	_____

Settlement Pending? Yes No $ _____

Inheritance Pending? Yes No $ _____

Do you have or expect to have health insurance?

Yes-start date _____

No- please explain _____

_____

For more information on health insurance go to healthcare.gov or call 1-800-318-2596

Would you like information about the Healthy Montana Kids (HMK) program?

Yes or No (Please circle one)

Financial Assistance & Extended Payment Plan Application (continued)

Monthly Income (Proof of Income Required)

Employment (Gross Wages)	$ _____
Part-Time Job (Gross Wages)	$ _____
Social Security	$ _____
Social Security Disability	$ _____
Disability Pension	$ _____
Veteran Pension	$ _____
Retirement (all sources)	$ _____
Unemployment	$ _____
Workers Compensation	$ _____
Union Benefits	$ _____
Inheritance	$ _____
Public Assistance (TANF)	$ _____
SNAP (Food Stamps)	$ _____
Alimony/Child Support	$ _____
Rents/Royalties	$ _____
Savings Interest	$ _____
Investment Income	$ _____
Other _____	$ _____
Total	$ _____

If you are claiming no income, how are you paying for living expenses?

Monthly Expenses

Rent or House Payment	$ _____
Car Payments (total)	$ _____
RV/Boat/Motorcycle (total)	$ _____
Student Loan Payment	$ _____
Other Loan Payment	$ _____
Food	$ _____
Electricity/Gas	$ _____
Phone/Cell Phone/Internet	$ _____
Pharmacy/Drugs	$ _____
Water	$ _____
Cable/Satellite TV	$ _____
Insurance	
Auto	$ _____
Health/Life	$ _____
Property	$ _____
Car Expense/Gas	$ _____
Child Care	$ _____
Child Support/Alimony	$ _____
Other _____	$ _____

Collections:_____

Owing: _____ Payment $ _____

Credit Cards:_____

Owing: _____ Payment $ _____

Doctor Name:_____

Owing: _____ Payment $ _____

Dentist Name: _____

Owing: _____ Payment $ _____

Hospital Name: _____

Owing: _____ Payment $ _____

Total Monthly Expenses $ _____

Certification

The information provided in this application is true and correct to the best of my knowledge. Frances Mahon Deaconess Hospital may verify any of this information.

I understand additional information may be requested to qualify. False information will result in a denied application.

Signature, Head of Household Date

Signature, Spouse Date

Return completed application and proof of income to the FMDH Patient Accounting Office.

Additional Information

Please provide any additional information that you would like to be considered as part of your applications: