ROUNDUP MEMORIAL
HEALTHCARE

REQUEST FOR FINANCIAL ASSISTANCE

Dear Patient and Family,

In Keeping with our mission and core values, Roundup Memorial Healthcare is committed to providing health care for people regardless of their ability to pay.

Assistance with medical bills. We recognize that medical bills may be difficult to pay. If you do not have health insurance or are concerned that you may be unable to pay for all or part of your health care services, you may apply for financial assistance by completing the items in the list below. If you have questions, please call our Patient Account Representatives at (406)323-3337 or (406)323-2301.

What is available? We will work with you to see if you qualify for Medicaid, Medicare, Veterans Administration, Disability, Crime Victims, Children's Insurance Program (CHIP), or other options. If you qualify for Financial Assistance, some or all of you bill may be paid by these assistance programs.

How do you apply? To be considered for assistance, please complete and return this form to Roundup Memorial Healthcare, Patient Account Services, PO. Box 40, Roundup, MT 59072. Completion of this application may enable you to receive free or reduced cost care.

To be considered for financial assistance, you must supply the following:

- Completed and signed application form
- Proof that Medicaid Application was denied
- Previous Year's tax return including all schedules with W-2's (Federal and State)
- Copies of earnings statements for each person in the household for the last 3 months (pay stubs, social security, unemployment, retirement, pension, etc.)
- One copy of each of your last three bank and investment account statements
- Copy of all insurance cards, including Medicare, Medicaid, Veterans Administration, BCBS, etc.

Without the above listed items, we may not be able to process your application.

If you have questions, Please call our Patient Account Representatives at (406) 323-3337 or (406) 323-2301.

Please return this application within 20 days, we will notify you of our decision within 45 days. You have the right to appeal our determination.

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: _____

Persons In Family	Federal Poverty Level
1	$ 13,590.00
2	$ 18,310.00
3	$ 23,030.00
4	$ 27,750.00
5	$ 32,470.00
6	$ 37,190.00
7	$ 41,910.00
8	$ 46,630.00
For each additional person, add	$ 4,720.00

2022 ANNUAL POVERTY GUIDELINES

FPL	125%	150%	175%	200%
FAMILY SIZE	100%	75%	50%	25%
1	$ 16,988.00	$ 20,385.00	$ 23,783.00	$ 27,180.00
2	$ 22,888.00	$ 27,465.00	$ 32,043.00	$ 36,620.00
3	$ 28,788.00	$ 34,545.00	$ 40,303.00	$ 46,060.00
4	$ 34,688.00	$ 41,625.00	$ 48,563.00	$ 55,500.00
5	$ 40,588.00	$ 48,705.00	$ 56,823.00	$ 64,940.00
6	$ 46,488.00	$ 55,785.00	$ 65,083.00	$ 74,380.00
7	$ 52,388.00	$ 62,865.00	$ 73,343.00	$ 83,820.00
8	$ 58,288.00	$ 69,945.00	$ 81,603.00	$ 93,260.00

2022 MONTHLY POVERTY GUIDELINES

FPL	125%	150%	175%	200%
FAMILY SIZE	100%	75%	50%	25%
1	$ 1,416.00	$ 1,699.00	$ 1,982.00	$ 2,265.00
2	$ 1,907.00	$ 2,289.00	$ 2,670.00	$ 3,052.00
3	$ 2,399.00	$ 2,879.00	$ 3,359.00	$ 3,838.00
4	$ 2,891.00	$ 3,469.00	$ 4,047.00	$ 4,625.00
5	$ 3,382.00	$ 4,059.00	$ 4,735.00	$ 5,412.00
6	$ 3,874.00	$ 4,649.00	$ 5,424.00	$ 6,198.00
7	$ 4,366.00	$ 5,239.00	$ 6,112.00	$ 6,985.00
8	$ 4,857.00	$ 5,829.00	$ 6,800.00	$ 7,772.00

Verification of the poverty guidelines can be found on
https://www.benefits.gov/benefit/1633#Eligibility_Checker