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 your 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, P.O. 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, pensions, 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.

Questions? 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 notified of our decision within 20 days. You have the right to appeal our determination.

Rev 08/2014

1202 Third Street West PO Box 40 Roundup, MT, 59072 Telephone: (406) 323-2301 Fax: (406) 323-3681

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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 one 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 homeless clinic**

** **If you checked above, skip to page 2 and sign Release of Information Authorization. If not, go to page 2 and complete application.**

PATIENT(S) NAME/ACCT #: ____

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	**$ ________**	**$ ________**	**$ ________**	**$ ________**

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	NO
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		

PATIENT(S) NAME/ACCT #: ____

OFFICE USE ONLY

AMOUNTS: Hospital $ __________ Clinic $ __________

Approved: __________% Disapproved: __________ Date: ______________

PAR: ____________________ BOM: __________________ CEO: __________________

Roundup Memorial Healthcare
Sliding Scale by income range, Effective January 1, 2016

2016 HHS Poverty Guidelines	
Persons in Family	**FPL**
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890
For each additional person, add	$4,160

FPL	Zero to 125% FPL	More than 125% to 150% FPL	More than 150% to 175% FPL	More than 175% to 200% FPL	More than 200% FPL
Patient Pays	No Cost	25%	50%	75%	100%
Family Size	Income Range				
1	$0 to 14,850	$14,851 to 17,820	$17,821 to 20,790	$20,791 to 23,760	Over $23,760
2	$0 to 20,025	$20,026 to 24,030	$24,031 to 28,035	$28,036 to 32,040	Over $32,040
3	$0 to 25,200	$25,201 to 30,240	$30,241 to 35,280	$35,281 to 40,320	Over $40,320
4	$0 to 30,375	$30,376 to 36,450	$36,451 to 42,525	$42,526 to 48,600	Over $48,600
5	$0 to 35,550	$35,551 to 42,660	$42,661 to 49,770	$49,771 to 56,880	Over $56,880
6	$0 to 40,725	$40,726 to 48,870	$48,871 to 57,015	$57,016 to 65,160	Over $65,160
7	$0 to 45,913	$45,914 to 55,095	$55,096 to 64,278	$68,279 to 73,460	Over $73,460
8	$0 to 51,113	$51,114 to 61,335	$61,336 to 71,558	$71,558 to 81,780	Over $81,780

For family units with more than 8 members, add $4,160 for each additional member.