



Request for Financial Assistance

Dear Patient and Family,

In keeping with our mission and core values, Billings Clinic 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 Financial Representatives at (406) 238-2250 or toll free 1-800-332-7156.

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), interest-free payment plan options or our Financial Assistance Program. If you qualify for Financial Assistance, some or all of your fees may be lowered.

How do you apply? To be considered for assistance, please complete and return this form to Billings Clinic Patient Financial Services; Dept. 8227; PO Box 35100; Billings, MT 59107-5100. 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.
- Previous year's tax return (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.
- Letter explaining your need for financial assistance.
- Letter of support from the assisting party if the household is receiving assistance from family or friends.
- Without the above listed items, we may not be able to process your application.

Questions? If you have questions, please call our Patient Financial Representatives at (406) 238-2250 or 1-800-332-7156, ext. 2250.

Please return this application within 20 days. We will notify you in writing of our decision within 20 days. You have the right to appeal our determination.

Sincerely,

Billings Clinic

1. **Head of Household** _____ Spouse _____

Address _____

Number and Street

City

State

Zip Code

Telephone(____) _____

2. **Occupation (self)** _____ Date of Birth _____ Social Security No. _____

Employer _____

Name

Address

Phone Number

Occupation (spouse) _____ Date of Birth _____ Social Security No. _____

Employer _____

Name

Address

Phone Number

3. Other members living in the household.

Name (*First and Last Name*) _____ **Relationship** _____ **Date of Birth** _____

Name (<i>First and Last Name</i>)	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Income: List all income for household

For Last 3 Months

For Last 12 Months

Wages (Before Taxes) \$ _____ \$ _____

Farm or Self-Employed \$ _____ \$ _____

Public Assistance Food Stamps GA AFDC Other \$ _____ \$ _____

Social Security/Supplemental Security (SSI) \$ _____ \$ _____

Unemployment compensation \$ _____ \$ _____

Workers compensation \$ _____ \$ _____

Alimony \$ _____ \$ _____

Child support \$ _____ \$ _____

Pensions/retirement \$ _____ \$ _____

Income from dividends, interest, rent \$ _____ \$ _____

Education grants/loans \$ _____ \$ _____

Inheritance \$ _____ \$ _____

Oil and mineral royalties \$ _____ \$ _____

Native American income monies \$ _____ \$ _____

Income tax refunds Federal State \$ _____ \$ _____

Settlement income Worker's Compensation \$ _____ \$ _____

Bodily Injury Lawsuit MVA Other \$ _____ \$ _____

Other income (please explain) _____ \$ _____ \$ _____

TOTALS:

\$ _____

\$ _____

Account number/s _____

Account number/s _____

Please list Name(s) of Patient(s) and Date(s) of Service

Patient Name _____ Date(s) of Service _____

Patient Name _____ Date(s) of Service _____

**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 Billings Clinic the full amount recovered.

I authorize a representative of Billings Clinic to obtain personal, financial or medical information from any source deemed necessary to determine my eligibility for financial assistance. In so authorizing, I release Billings Clinic and its representatives from any or all liability connected with this release.

Please check the name of the facilities where you have an outstanding balance to be considered with the application:

- Aspen Meadows Behavioral Health Billings Clinic Hospital Billings Clinic

Signature of Head of Household

Date

Signature of Spouse

Date

Mailing Address:

Billings Clinic
Patient Financial Services 8227
PO Box 35100
Billings, MT 59107

Phone Numbers:

(406) 238-2250
1-800-332-7156, ext. 2250

Financial Assistance Check List

Please be sure that you have answered all the questions on the application and have included copies of documents that apply to you.

- Did you and your spouse sign the application?
- Did you enclose your most recent Tax Return (Federal and State)?
- If you did not enclose a copy of last year's tax return, why? _____
- Did you enclose copies of your earnings statements for the last 3 months?
- Did you enclose copies of all award letters for unemployment, food stamps, Lieap, financial aid for college, or general assistance?
- Did you enclose a copy of your Social Security check?
- Did you enclose a copy of each of your last three bank and investment account statements?
- Did you write a letter explaining your need for financial assistance?
- If you are currently unemployed, when was your last day of work? _____
- Will you receive unemployment? Yes _____ No _____
- If you are temporarily out of work, do you expect to return to the same job? Yes _____ No _____ If so, when _____
- Have you included a letter of support from family or friends helping you financially?