CENTRAL MONTANA MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Questions? Use the QR code on the right or go to cmmc.health to access CMMC's Assistance Policy OR call Patient Financial Services (406)535-1457 or 1(800)332-7156, x2601. Interpreter Services/Language Line 1(833)703-0016

1) Household Information:

Applicant (First, Middle, Last):_____ Date of Birth:_____

Spouse/Partner(First, Middle, Last:_____ Date of Birth:_____

Address:_____ Phone:_____

City, State, Zip:_____ Cell:_____

2) Other Household Members:

Name (First, Last):	Date of Birth:	Relationship to Applicant:

*More members can be listed on an additional page.

3) Check all CMMC locations you've received services from:

☐ Hospital ☐ DME ☐ Clinic ☐ Home Health

4) Public Assistance Benefits:

Are you currently receiving benefits from any of the following programs? If so, you may automatically qualify for 100% financial assistance. Please check all that apply.

Include documentation of your confirmation/eligibility in the following program(s) with your application:

- ☐ SNAP - Supplemental Nutrition Assistance Program
- ☐ WIC - Women, Infants, & Children Supplemental Nutrition Program
- ☐ Subsidized/Low Income Housing or Rental Assistance
- ☐ Low Income Energy Assistance Program (LIEAP)
- ☐ Low Income Prescription Programs
- ☐ Homeless or receiving care from a homeless shelter, clinic, or center

*If you checked any boxes above, skip to section 8.

5) Retired/Social Security Applicants:

Does your household have any other income sources besides social security and/or disability?

☐ Yes - continue to next section

☐ No - skip to section 8.

6) Employment Status:

Income Source	Applicant	Spouse	Required Documents
Employer Name & Length of Employment			Last 3 months of paystubs
Length of Unemployment			Unemployment award letter
Self-Employment (Type of self-employment)			Current YTD profit/loss statement
Retirement (S.S. IRA's, pension, etc.)			1099s
Length of Disability			Disability award letter from govt and/or private insurer
Student-school enrolled			N/A
Other Income-(rental income, interest, dividends, etc.)			Federal tax return

Required documentation for all applicants:

1) Copy of previous year's federal tax return, including all supporting schedules
2) Copy of most recent statements, including checking, savings, or any investment accounts
3) In event that you do not have requires documents; a letter of explanation must be submitted.

****Your financial assistance application will not be processed until all required documents are received****

7) Health Insurance Information:

☐ I have health insurance - Company/Plan Name:

Applicant:_____ Spouse/Partner:_____

☐ Health insurance is available to me, but I have declines or opted out. Reason:

Applicant:_____ Spouse/Partner:_____

☐ Payment is available to Applicant or Spouse/Partner through Health Share

☐ Other:_____

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8) Release of Information and Attestation for Financial Assistance:

I certify that the information I have provided is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services provided by Central Montana Medical Center and its affiliated entities. I give permission to Central Montana Medical Center and its affiliated entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Central Montana Medical Center and its affiliates and representatives to investigate the information contained herein.

Signature of Applicant (Patient, Parent, or Guardian): Date:

_____ _____

Signature of Spouse/Partner: Date:

_____ _____

Please mail your application and documents to:

Central Montana Medical Center
408 Wendell Ave
Lewistown, MT 59457

Questions? Call Patient Financial Representatives: (406)535-1457 or 1(800)332-7156, ext. 2601