Mineral Community Hospital

Here when you need us

FINANCIAL ASSISTANCE APPLICATION

INSTRUCTIONS: Please complete all information on the following application and send it back to the hospital **with** the following information: last month's bank statement, last month's rent receipt, last month's utility bills, last month's pay stubs and last year's tax return. If someone is providing room and board or is helping to pay your bills, a letter of support will need to be sent in with this financial statement.

Patient Account #_____

Responsible Person _____

Patient Name _____

Mailing Address _____City_____ State_____ Zip Code_____

Home Phone _____ Cell Phone _____ Alternate Phone _____

Number of family members in home: Adults _____ Children_____

Total household income _____

Mortgage / Rent _____

Electric bill _____ Water _____ Heating fuel _____

Garbage _____ Phone _____ Internet_____

Auto loans _____ Auto insurance _____

Home / Renter's insurance_____

Medical bills_____ Medical insurance _____

Credit Cards _____

Food _____ Food stamp amount _____

Total Monthly debts_____

Please Check Yes or No

Own Home: Yes ☐ No ☐ Assessed value_____

Own 2nd Home/Property: Yes ☐ No ☐ Assessed value _____

Life insurance policy: Yes ☐ No ☐ Cash value_____

Checking account: Yes ☐ No ☐ Balance $_____

Savings account: Yes ☐ No ☐ Balance $_____

Money Market, IRAs, CDs, Stocks, Bonds: Yes ☐ No ☐

Cash value $_____

Automobiles: Yes ☐ No ☐

Year _____ Make _____ Model _____

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Recreational vehicles: Yes ☐ No ☐

Year _____ Make _____ Model _____

Have you applied for Montana Medicaid? Yes ☐ No ☐ Date Applied _____

Have you applied for Insurance under the ACA? Yes ☐ No ☐ Date Applied _____

Are you?	Yes	No
Homeless	_____	_____
Unemployed	_____	_____
Uninsured	_____	_____

I authorize MCH to obtain confidential personal, employment, medical, financial and other information about me from credit institutions and agencies to support the processing to this statement. MCH, in accordance with the relevant laws, will use the acquired information solely for purposes directly connected with administration of uncompensated care. MCH will only release confidential information only as authorized by law.

I certify, under the penalty of perjury, that all my answers are correct and complete to the best of my knowledge. I understand and agree to provide documents to prove what I have stated.

_____ _____ _____

Your Signature Date Witness Signature if signed by X