Billings Clinic

ATTENTION: MONTANA RESIDENTS BETWEEN AGES 19-64

Did you know there is now a new affordable health insurance plan available for Montana Residents ages 19-64* beginning January 1, 2016?

Does your income fall within these levels?

- ❑ Single person earning less than $16,243
- ❑ Family of 2: less than $21,983
- ❑ Family of 3: less than $27,724
- ❑ Family of 4: less than $33,465
- ❑ Family of 5: less than $39,206

Are you currently receiving benefits for any of the public assistance programs listed 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)

If you answered "yes" to any of the above criteria, you may qualify for the new Montana HELP health insurance plan (Medicaid expansion). As of January 1, 2016, Billings Clinic's policy **requires** individuals to apply for the Montana HELP plan before being considered for financial assistance for medically necessary services.

To apply for the Montana HELP plan, use any of the following options:

- Online at *CoverMT.org* or *Healthcare.gov*
- Call 1-800-318-2596 (available 24 hours a day, 7 days a week)
- Meet with a Billings Clinic representative:
  - Office hours: 8 am – 5 pm, Monday - Friday
  - Office locations: Billings Clinic Downtown (by SameDay Care) or Hospital (in Atrium)
  - Phone numbers: 406-238-2601 or 1-800-332-7156, ext. 2601
- If you **qualify** for the Montana HELP plan and are currently receiving a billing statement with a balance owed from Billings Clinic, please complete the attached Billings Clinic financial assistance application including the required documents. You may qualify for financial assistance for prior balances owed.
- If you are **denied** eligibility for the Montana HELP plan, please provide proof of the denial and complete the attached Billings Clinic financial assistance application including the required documents.
- If you have **answered "no"** to the above criteria, please complete the attached Billings Clinic financial assistance application. You may qualify for financial assistance.

* Have questions about insuring children under the age of 19? Please use one of the following options:

- Online at *dphhs.mt.gov/hmk*
- Call 1-888-706-1535 (Healthy Montana Kids helpline)
- Meet with a Billings Clinic representative:
  - Office hours: 8 am – 4:30 pm
  - Office location: Billings Clinic Hospital
  - Phone numbers: 406-238-2802 and 406-238-2834

Financial assistance provided by Billings Clinic under the Financial Assistance Policy is secondary to all Third Party Payers and other financial resources available to the patient. Examples include Medicaid and other federal, state or county medical programs.

Financial Assistance Application

Billings Clinic

Clinic Account # ______________________

Hospital Account # ______________________

You may apply for financial assistance for you and your family 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.

We will work with you to see if you qualify for other health insurance programs, interest-free payment plan options, long-term loans, or our Financial Assistance Program. If you qualify for financial assistance, some or all of your balances may be reduced for medically-necessary services only. *Billings Clinic will determine if a service is medically necessary based on the Billings Clinic Financial Assistance Policy, available at www.billingsclinic.com/financial or by calling a Patient Financial Representative.*

1a. Household Information

Applicant: ______________________

Spouse: ______________________

Address: ______________________
Number and Street

____
City State Zip Code

Home Phone: (________) ______________________

Cell Phone: (________) ______________________

Occupation: (You) ______________________

Date of Birth: ______________________

Social Security No.: ______________________

Employer: ______________________

Employer Address: ______________________

Phone: (_____) ______________________

Occupation: (Spouse) ______________________

Date of Birth: ______________________

Social Security No.: ______________________

Employer: ______________________

Employer Address: ______________________

Phone: (_____) ______________________

Other members living in the household:
(Add more on another sheet of paper)

____
First and Last Name
____
Relationship
____
Date of Birth

____
First and Last Name
____
Relationship
____
Date of Birth

____
First and Last Name
____
Relationship
____
Date of Birth

____
First and Last Name
____
Relationship
____
Date of Birth

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

1b. Are you currently receiving benefits for any of the 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). Check the box for the program(s) you participate in:

❑ 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 a box, skip to page 4 and sign part b. If not, go to page 2.

Questions? Call Patient Financial Representatives: (406)238-2601 or toll free 1(800) 332-7156, ext. 2601.

If you are not currently receiving benefits for any of the public assistance programs listed on page 1b, please complete the remainder of this form.

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

- ❑ Completed and signed application form
- ❑ Copies of most recent year's tax returns (federal and state), all pages and schedules, including W-2s
- ❑ Copies of earnings statements for the applicant and his/her spouse for the last three (3) months (pay stubs, Social Security, unemployment, retirement, pensions, child support, federal student aid)
- ❑ One copy of each of your last three bank statements – all pages
- ❑ One copy of each of your last three pension/investment account statements (savings, CDs, stocks, etc.)
- ❑ Letter explaining your need for financial assistance

Without the above listed items, your application could be denied as incomplete.

Please return this signed application and the above listed items within four (4) weeks. We will notify you in writing of our decision within 45 days of receiving a complete application. You have the right to appeal our determination.

Income - List all monthly gross income	**Applicant**	**Spouse**	**Other**	**Total**
Gross wages from paycheck				
Farm or self employed				
Social Security/SSI/SSDI				
Unemployment compensation				
Workers compensation				
Alimony				
Child support				
Pension/retirement				
Income from dividends, interest, rent				
Education grants/loans				
Inheritance				
Oil and mineral royalties/land lease				
Native American income				
Income tax refunds: ❑ federal ❑ state				
Settlement income: ❑ worker's comp. ❑ bodily injury ❑ lawsuit ❑ other ❑ motor vehicle accident				
Other income (please explain) ______________________________				
Total				

- ❑ 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 ____________________

Questions? Call Patient Financial Representatives: (406)238-2601 or toll free 1(800) 332-7156, ext. 2601.

Assets - Financial (*Accounts I Own*)	Current Balance	Financial Institution Holding Account
Checking account		
Savings account #1		
Savings account #2		
CDs/bonds		
Stock/mutual funds		
Retirement funds		
Other: (Please List)		
Total	A	

For internal use only

Total Assets A + B1	
Total Liabilities B2 + C1	
Total Monthly Payments B3 + C2 + D	

Assets - Property (*Property I Own*)	Current Value of Property	Amount Owed on Property	Monthly Payment (if loan associated with property)
House			
Auto #1			
Auto #2			
Auto #3			
RV			
Boat			
Motorcycle/ATV			
Rental property			
Other: (Please List)			
Total	B1	B2	B3

Liabilities (*Balances I Owe*)	Current Balance of Loan	Monthly Payment
Bank or credit union loans		
Credit cards		
Department store cards		
Outstanding medical bills		
School loans		
Other: (Please List)		
Total	C1	C2

Monthly Expenses	Amount
Rent	
Groceries/household products	
Lights & heat	
Phone (cell & home)	
Water & sewer	
Gasoline	
Insurance (health, home, auto, life, renter's, etc.)	
Child care	
Child support	
Clothing	
Entertainment including TV, internet, movies, etc.	
Prescriptions	
Other: (Please List)	
Total	D

Questions? Call Patient Financial Representatives: (406)238-2601 or toll free 1(800) 332-7156, ext. 2601.

4a. Financial Assistance Application Check List

(For those filling out entire form)

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

- ❑ Did you and your spouse sign and date the application?
- ❑ Did you enclose your most recent tax returns (federal and state), all pages and schedules, including W-2s?
- ❑ If you did not enclose a copy of your tax returns, why? ____________________________
- ❑ Did you enclose copies of your earnings statements for the last 3 months?
- ❑ Did you enclose copies of all award letters for unemployment, financial aid for college, or general assistance?
- ❑ Did you enclose a copy of your Social Security check or copy of award letter?
- ❑ Did you enclose a copy of each of your last three bank statements?
- ❑ Did you enclose a copy of each of your last three pension/investment account statements (savings, CDs, stocks, etc.)?
- ❑ Did you write a letter explaining your need for financial assistance?

You may also qualify for the Medication Assistance Program (MAP) for your prescription needs. To make an appointment with a MAP advocate, please call (406)238-2501 or 1(800) 332-7156.

4b. Release of Information Authorization for Financial Assistance

(For ALL Applicants)

I certify that the information I provided is true and correct to the best of my knowledge. I will cooperate to obtain assistance and pay Billings Clinic any money I receive.

I will provide Billings Clinic with information about any other means to pay this bill such as Medicaid, Crime Victims Fund, automobile or home insurance policies, etc. I will cooperate with Billings Clinic to apply and obtain assistance from any government agency that I am qualified to receive assistance from and will pay Billings Clinic any money I receive relating to these medical services.

I authorize Billings Clinic to contact employers, financial institutions, state and federal agencies, and other third parties to verify the information I have provided or to obtain additional information regarding my finances. I authorize any such entities to provide information to Billings Clinic about my current assets, liabilities, credit, and other information as reasonably requested.

I release Billings Clinic and its representatives from any and all liability connected with this release of information. Please check the name of the facilities where you have an outstanding balance to be considered with this application:

❑ Billings Clinic ❑ Billings Clinic Hospital

❑ Aspen Meadows ❑ Home Oxygen & Medical Equipment

______________________________ ______________

Signature of Applicant (Patient, Parent or Guardian) Date

______________________________ ______________

Signature of Spouse Date

Mailing Address:

Billings Clinic
Attn: PFS Financial Assistance
PO Box 35100
Billings, MT 59107

REV 10/15 03366879

Questions? Call Patient Financial Representatives: (406)238-2601 or toll free 1(800) 332-7156, ext. 2601.