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Billings Clinic

Financial Assistance Application

Questions? Use the QR code on the right or go to www.billingsclinic.com to access Billings Clinic Financial Assistance Policy OR Call Patient Financial Services (406) 238-2601 or 1 (800) 332-7156, x2601.
Interpreter Services / Language Line 833-703-0016

1) Applicant/Responsible Party:

Name (first, middle, last): _____ Date of Birth: _____

Address: _____ Phone #: _____

2) Spouse/Partner:

Name (first, middle, last): _____ Date of Birth: _____

3) Family Members:

Please list other family members whom you financially support (*provide more than 50% of living expenses for 1 year*):

	Name	Date of Birth	Relationship to Applicant
1)			
2)			
3)			
4)			

*if more than 4, please list members on an additional page.

4) *Please check all locations where you or a family member received services from Billings Clinic:*
******Financial Assistance for services obtained at the Broadwater Billings Clinic location requires a separate application.***

- ☐ Billings Locations/Bozeman/Regional Clinics
- ☐ Billings Downtown Atrium Pharmacy
- ☐ Billings Home Oxygen & Durable Medical Equipment
- ☐ Stillwater Billings Clinic in Columbus, MT
- ☐ Broadwater Billings Clinic in Townsend, MT
- ☐ Other:

5) 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 confimation/eligibility in the following program(s) with your application:

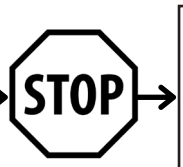
- ☐ SNAP - Supplemental Nutrition Assistance Program
- ☐ WIC - Women, Infants, & Children Supplemental Nutrition Program
- ☐ Subsidized/Low Income Housing or Rental Assistance
- ☐ Low Income Energy Assistance Program (LIEAP)
- ☐ Low Income Prescription Programs
- ☐ Homeless or receiving care from a homeless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

If you checked any boxes on the left, skip to Section 9 to sign and date form.

Please include program documentation to complete the application.

6) Retired/Social Security Applicants:

Does your household have any other income source besides social security and/or disability? Yes ☐ No ☐



If "Yes", please move to the next section on page 2.

If you answered "No", skip to Section 9 to sign and date form.
Please include your most recent bank statements to complete the application.

Questions? Call Patient Financial Services (406) 238-2601 or 1 (800) 332-7156, x2601.
Fax 406-238-5323

7) Employment Status:

	Employed	Unemployed	Self Employed	Retired	Disabled	Student	Other income
Please write your answers in boxes	Employer name & length of time with employer	Length of unemployment	Type of self-employment	Type of retirement (Soc Sec, IRAS, pension, etc.)	Length of disability	School attending	Type of other income (rental income, interest, dividends, etc.)
Applicant							
Spouse/Partner							
Required documentation for each applicable box above →	Include last 3 months of pay stubs including year to date detail	Include unemployment award letter	Include current 'year-to-date' profit/loss statement	Include 1099s for social security, pensions, retirement, etc.	Include disability award letter from Federal or State govt and/or private insurer	N/A	Include Federal tax return, including all supporting schedules

REQUIRED DOCUMENTATION FOR ALL APPLICANTS:	1) Include previous year's Federal tax return, including all supporting schedules	2) Include **most recent** statements, including checking, savings, or any investment accounts	3) if you do not have the required supporting documents, please provide a letter of explanation **Please do not submit original documents	****Your financial assistance application will not be processed until all required documents are received****

8) Health Insurance Information:

Please check as many boxes as apply:

☐ I have health insurance.
Company/Plan Name for Applicant:_____
Company/Plan Name for Spouse/Partner:_____

☐ Health insurance is available to me, but I have declined or opted out.
Reason for declining/opting out Applicant:_____
Reason for declining/opting out Spouse/Partner:_____

☐ Payments are available to Applicant or Spouse/Partner through Health Share.

☐ Other:_____ Spouse/Partner:_____

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9) Release of Information and Attestation for Financial Assistance:

For *ALL APPLICANTS*

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 Billings Clinic or affiliated entities. I give permission to Billings Clinic and all affiliated clinics, hospitals, and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Billings Clinic and its affiliates and representatives to investigate the information contained herein.

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

Signature of Spouse/Partner: Date:

You may also qualify for the Medication Assistance Program (MAP) for your prescription needs.
To speak with a MAP advocate, call (406) 238-2111.

Please mail your application and documentation to:
Billings Clinic
Attn: Financial Assistance
PO Box 35100
Billings, MT 59107
Questions? (406) 238-2601