Bozeman Health

Financial Assistance Application

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 one year).* If more than 4, please list members on an additional page.

Name	Date of Birth	Relationship to Applicant

4) Employment Status

	Employed	Unemployed	Self Employed	Retired	Disabled	Student	Other Income
Please write your answers in boxes below	Employer name and Length of time with employer	Length of unemployment	Type of self-employment	Types of retirement (Soc Sec, IRA's, pension, etc.	Length of Disability	School attending	Type of other income (rental income, interest, dividends, etc.)
Applicant							
Spouse/ Partner							
Required Documentation	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

Applicants net monthly "take home" income: _____

Spouse/partner net monthly "take home" income: _____

As part of our financial assistance process, you must contact First Source at 406-414-5595 to determine whether you qualify for Medicaid. Once this process is complete, we can proceed with reviewing your financial assistance application.

Bozeman Health

Patient Notification

All reasonable efforts will be made to notify a patient regarding the availability of financial assistance under this policy by:

Attempting to determine whether a patient has third-party coverage for any part of the emergency or medically necessary health care service provided.

a) If a patient does not have third-party coverage, a patient advocate from the First Source program will screen all inpatient cases and any outpatient cases exceeding $1,000 in total charges to determine if the patient qualifies for third-party funding.
b) If the patient does not have or qualify for third-party funding, the customer service team can explain the Financial Assistance policy, provide an application for the patient, and assist with completing the application, if desired.

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

5) Complete and sign this application plus provide the required documentation as outlined below:

Required documentation for all applicants	**1)** Include previous 3 years tax return, including all supporting schedules.	**2)** Include most recent statements, including checking, savings, and/or any investment accounts.	**3)** If you do not have required supporting documents, please provide a letter of explanation.	****Your financial application will not be processed until all required documents are received.****

6) 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 Bozeman Health or affiliated entities. I give permission to Bozeman Health and all affiliated clinics, hospitals, and entities to share the information necessary to consider my financial assistance request. I hereby grant permission to Bozeman Health 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, deliver or email your completed application and documentation.

Bozeman Health
Attn: Financial Services Customer Service
1600 Ellis St., Third Floor
Bozeman, MT 59715

Email: collectionspecialist@bozemanhealth.org

Applications may be delivered in person to Patient Financial Services customer service, 1600 Ellis Street, Third Floor, Bozeman, MT 59715 (across Highland Boulevard from the hospital in the Legacy building).

For more information or assistance completing the financial assistance application, contact Bozeman Health at 406-414-1720.

A patient qualifying for financial assistance under Bozeman Health's Financial Assistance Policy with respect to emergency or medically necessary health care services will not be charged more than the amounts generally billed by Bozeman Health for the same services to patients who have insurance covering such care. For more information on the AGB calculation, go to this link below:

https://bozemanhealth.org/services/patient-financial-services/financial-assistance/#financial-documents

Bozeman Health Deaconess Regional Medical Center
Bozeman Health Big Sky Medical Center