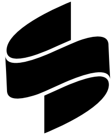

St. Peter's Health

2475 Broadway
Helena, MT 59601
406-442-2480

sphealth.org

PATIENT / APPLICANT FINANCIAL STATEMENT

ACCOUNT NUMBER										

Department Location: ______________

Guarantor's Last Name, First	Date of Birth	Social Security Number	Source of income: ☐Employed ☐Retired ☐Unemployed ☐Disabled
Spouse's Last Name, First	Date of Birth	Social Security Number	Source of income: ☐Employed ☐Retired ☐Unemployed ☐Disabled

Guarantor's Address	Home Telephone Number	Cell Telephone Number (optional)

Dependant's Last Name, First	Date of Birth	Dependant's Last Name, First	Date of Birth
Dependant's Last Name, First	Date of Birth	Dependant's Last Name, First	Date of Birth
Dependant's Last Name, First	Date of Birth	Dependant's Last Name, First	Date of Birth

☐ **I do need Financial Assistance.** ☐ **I do not need Financial Assistance.**

Please read before signing. I CERTIFY the information I have provided is true and accurate to the best of my knowledge. I agree to apply for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay my bill(s) and will take all action necessary to obtain assistance from the above sources. I understand that if I do not cooperate with and provide St. Peter's Health, within 45 days from the date of service, ANY additional information requested, my application for possible financial assistance may be denied. I hereby grant permission and authorize any accredited agent of the Department of Health and Human Services to disclose to St. Peter's Health ALL information regarding the status of my Medicaid application and, if the application is not approved, the reason for such. I will ASSIGN to ST. PETER'S HEALTH ALL FUNDS received from the above sources, which are provided to help with this MEDICAL BILL(S). I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s) and provider(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communications and/or oral discussions between St. Peter's Health and me regarding matters relating to services provided to me by St. Peter's Health. I understand that the information which I submit is subject to verification by ST. PETER'S HEALTH, including credit reporting agencies, and subject to review by FEDERAL, and/or STATE AGENCIES and others as required. I UNDERSTAND that if any information I have given proves to be untrue, ST. PETER'S HEALTH will reevaluate my financial status and take whatever action becomes appropriate.

SIGNATURE OF APPLICANT	***DATE***	***AUTHORIZED STAFF (REQUIRED)***	***DATE***

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In order to be considered for our assistance program, a completed application form and all supporting documentation must be received within 30 days. Failing to provide the requested information may lead to the denial of assistance. We have received your application but will need to have additional information to process your request. Please furnish the below documentation for all family members of the household by______________.

*****For those that are uninsured we will refer you to attempt to qualify you for any Federal or State available insurance coverage. You are expected to follow through/comply with government required application process***

Market Place/Medicaid Expansion (HELP) Insurance

_____Proof of application being accepted with effective date of coverage
_____Proof of application being filed and coverage denied

Current approval letter for the following public assistance:

____Snap(Food Stamps) ______Housing _____ L.E.A.P (Energy Assistance)

Earnings:

_____ 1040 Federal Tax Return, most current year filed.
_____ Paystubs for the last current 9 months, (for all working members of the household).
_____ All last year bank statements plus year to date bank statements
_____ 9 Month Profit and Loss Statement

Other Earnings:

_____Unemployment compensation
_____ Workers' compensation
_____ Social Security and Pension Earnings (Example: award letter)
_____ Veterans' payments
_____ Survivor benefits
_____ Interest and Dividends
_____ Rentals
_____ Royalties
_____ Income from estates
_____ Trusts
_____ Educational assistance
_____ Alimony
_____Child support
_____ Assistance from outside the household

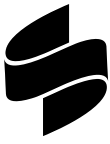
Assets:

_____ 3 months checking account statement ______I don't have a checking account
_____ 3 months savings account statements ______I don't have a savings account
_____ 3 months investment account statements ______I don't have any investments
_____If applicable address of secondary real estate and/or land

____

_____If you own two or more automobiles please provide the following on each:

Year __________ Year __________
Make __________ Make __________
Model __________ Model __________



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_____Written explanation of periods without income. How were you paying for food and housing?

____

____

____

_____If someone else is providing food and housing, please include a notarized statement from the individual(s) helping you.

_____Picture ID _____Signature

_____If you are unable to provide any of the require information; please include a notarized statement of what you do not have and why you are unable to obtain it.

_____Picture ID _____Patient signed while in the room

Signature: ____ Date:___________________________

Witness: ____ Date:___________________________
(Authorized hospital employee)

Financial Advocate: _________________________________ Phone:____406-447-2828_______