



Mountainview Medical Center

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Patient Financial Assistance Application: Mountainview Medical Center and Bair Medical Clinic

Mountainview Medical Center (MMC) and Bair Medical Clinic provides, within the limits of its resources, primary, secondary and long term care regardless of race, religion, age, sex or ability to pay.

Financial assistance is available based upon ability to pay.

Ability to pay is determined based upon published Federal Poverty Guidelines (FPG). For individuals or families with income at or below the FPG, 100% discount may be available. FPG guidelines are updated in February of each year.

Financial assistance from MMC is applied after consideration of all other potential third party sources, including Medicaid.

Qualification for financial assistance from MMC is determined from an application completed by the patient or responsible guarantor. A completed application with required documentation will be promptly reviewed. The applicant will be notified, in writing, of their eligibility status. If an applicant appears to be eligible for Medicaid or other governmental assistance, the applicant will be referred to those programs for assistance. If other assistance is denied, a written denial from that agency will qualify as additional support for MMC providing financial assistance. Final approval will be granted or denied by MMC's CEO. Special considerations will be taken into account on a case by case basis.

The following services are not subject to financial assistance:

- Elective Services
- Diagnostic testing or services received at other facilities
- Non-Diagnostic testing not required for medical purposes
- Professional fees or services charged by providers that are not billed by MMC

To determine if you might qualify for financial assistance, please refer to the MVMC assistance qualification matrix. Find your family size in the first column and your annual family income in that row. The discount you may be eligible for is found at the top of the column in which your annual income is found.

To apply for financial assistance, please complete the attached application and include the appropriate proof of income documentation. If you need help in completing the application process, Candi Richardson of patient financial services will be glad to assist you.

All approved applications are subject to update and review every six months.



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Please include the following applicable documentation with your application:

- Copy of your most recent filed federal income tax return
- Current pay records or written verification of wages from your employer for past 3 months
- Social Security Income, including SSI payments for dependents
- Alimony payments received for current year
- Any evidence of public assistance or denial of public assistance
- Evidence of any unemployment or workers compensation payments received in current year -
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Any questions regarding the MMC Financial Assistance Program may be directed to Candi at:



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16 West Main Street, White Sulphur Springs, Mt 59645

(406) 547-3321

Mountainview Medical Center and Bair Medical Clinic offer assistance to patients that would otherwise be unable to obtain medical care due to financial hardship through our Financial Assistance Program.

16 W. Main St. | White Sulphur Springs, MT 59645 | 406.547.3321(MMC) | Fax 406.547.3589
|www.mvmc.org This institution is an equal opportunity provider and employer.



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All assistance is based on total income and family size. *A family unit is defined as legally married persons and dependent minor children or as dependents listed on a federal income tax return.*

You must fill out an application and supply all necessary documents to be considered for this program. MMC must be provided enough documentation to determine if your family income falls within the FPGs as well as rule out any other government assistance programs. If approved, the program lasts for a six month period; after which, a patient must reapply with updated financial information.

To be eligible, you must first exhaust all possible insurance coverage, Medicare, Medicaid or any third party payment sources. You must have proof of denial/ acceptance if you could possibly be eligible for Medicaid or other assistance programs. The Financial Assistance program can be used with or without an insurance program if you are not eligible for one.

You must provide proof of income, government benefits such as unemployment and other income such as child/spousal support. **The most recent Tax Return is the preferred proof of income.** If this is unavailable, MMC reserves the right to request further information as needed to verify potential income.

You must fall within the poverty income guidelines established by the federal government as shown below.

2020 Federal Poverty Level

<i>Persons in Family/Household</i>	<i>250% Federal Poverty Guideline 100% Discount</i>
1	\$31,225
2	\$42,275
3	\$53,325
4	\$64,375
5	\$75,425
6	\$86,475
7	\$97,525
8*	\$108,575

*Add \$4,420 for each additional person above 8 household occupants

*The foregoing discount percentage has been established in a manner intended to comply with applicable Federal law, which provides that the Hospital may not bill a patient eligible for financial assistance more than the amounts general billed (“AGB”) by the Hospital to patients who have insurance covering such care. The Hospital has calculated its AGB using the look-back method set forth in applicable Treasury Regulations, considering amounts paid by Medicare and commercial payers.

FINANCIAL ASSISTANCE APPLICATION

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Family / Patient's Name _____ Date _____ Tel # _____

Address: _____ City _____ State _____

Employers name and address: _____

Social Security Number _____ / _____ / _____ Total number in household: _____

List all members of your immediate family living in your household. Please include their date of birth.

1. _____ DOB _____ 2. _____ DOB _____

3. _____ DOB _____ 4. _____ DOB _____

5. _____ DOB _____ 6. _____ DOB _____

Please check any of the following circumstances listed below that apply to you:

_____ I am not eligible for Medicaid, Medicare or other third party assistance.

_____ I cannot afford private health insurance.

_____ I am not able to afford the cost of my health care at this time.

List all sources of monthly income:

Employment and tips \$ _____ Unemployment compensation \$ _____

Food Stamps \$ _____ Child Support / Alimony \$ _____

Pension \$ _____ Social Security \$ _____

Other \$ _____ Total Gross Income \$ _____

List all household Savings and Checking accounts.

Institution 1: _____ Institution 2: _____

Institution 3: _____ Institution 4: _____

Total balance of all Savings Accounts: _____

Total balance of all Checking Accounts: _____

List all other assets. This can include stocks, land, trusts, retirement accounts, etc.

*MMC may require proof of assets in order to assess their value.

By affixing my signature below, I _____, attest that the information given above is a true representation of my financial situation. I acknowledge that verification in writing may be required.

_____ Date _____

Applicant or Family Representative

Request for Financial Assistance Checklist

Please provide all documents requested within 14 business days. Failure to return the application and/ or required documents could result in your request being denied. If you have any questions please call 406-547-3321

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___ COPY OF RECENT TAX RETURNS (INCLUDING SCHEDULE C IF SELF EMPLOYED)

___ COPY OF DENIAL LETTER FROM MT MEDICAID IF APPLICABLE

___ PROOF OF PRIMARY INSURANCE COVERAGE IF APPLICABLE

___ SIGNED AND DATED APPLICATION WITH ALL FAMILY MEMBERS LISTED

If you did not file the most recent years' taxes or feel that your current financial situation is not reflected in the tax information, please return the applicable following *in addition* to your tax return. Please note that further information may be required if proof of income cannot be determined by information provided.

___ SAVINGS ACCOUNT STATEMENT FOR THE LAST 3 MONTHS

___ CHECKING ACCOUNT STATEMENT FOR THE LAST 3 MONTHS

___ PROOF OF RECENT IRA/401K/PENSION STATUS

___ PAY STUBS FOR THE LAST 3 MONTHS

___ PROOF OF UNEMPLOYMENT

___ PROOF OF DISABILITY

We are happy to assist in completing applications related to Montana state programs, HMK, HMK Plus or Financial Assistance. You have the right to a copy of this form after you sign it.