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Policy #: PFS-03

Section: Patient Financial Services

Topic: Financial Assistance Program

Date Adopted: Reviewed: 08/03/2022

Last Revision: 01/30/2024

Authorized by:

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1. **Purpose:**

Mountainview Medical Center and its affiliates (collectively, “MMC”) are not-for-profit, tax-exempt entities with a charitable mission of providing emergency and medically necessary health care services to residents of Mountainview Medical Center service area regardless of their financial status and ability to pay. The purpose of this Financial Assistance Policy is to ensure that processes and procedures exist for identifying and assisting hospital patients whose care may be provided without charge or at a discount commensurate with their financial resources and ability to pay. This Policy applies to each hospital department in the facility operated by Mountainview Medical Center.

1. **Overview:**

In furtherance of its charitable mission, MVMC will provide both (i) emergency treatment to any person requiring such care; and (ii) medically necessary health care services to patients who are permanent residents of the Mountainview Medical Center service area (and others on a case-by-case basis) who meet the conditions and criteria set forth in this policy; in each case, without regard to the patients’ ability to pay for such care.

The Hospital will provide free emergency, medically necessary, or primary care services to persons or families where: (i) there is limited or no health insurance available; (ii) the patient fails to qualify for governmental assistance (for example, Medicare or Medicaid); (iii) the patient cooperates with the Hospital in providing the requested information demonstrating financial need, or other facts and circumstances readily demonstrate financial need; and (iv) the Hospital makes an administrative determination that financial assistance is appropriate based on the patient’s ability to pay (as established by family income or based on criteria demonstrating presumptive eligibility) and the size of the patient’s medical bills.

After MVMC determines that a patient is eligible for financial assistance, 100% of the patient or guarantor responsibility balance will be forgiven. MVMC will utilize the Financial Assistance Guidelines set forth in **Exhibit 1** to determine eligibility for financial assistance. The Guidelines reflect family income levels tied to the most recent Federal Poverty Guidelines, and will be adjusted annually to reflect the annual update to the Poverty Guidelines.

MMC will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the mission of MMC; (ii) explains the decision processes of who may be eligible for financial assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to patients who are uninsured or otherwise eligible.

1. **Nondiscrimination:**
2. The Hospital will render health care services, inpatient and outpatient, to all Montana residents who are in need of emergency or medically necessary care, regardless of the ability of the patient to pay for such services and regardless of whether and to what extent such patients may qualify for financial assistance pursuant to this policy.
3. The Hospital will not engage in any actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.
4. **US Citizenship and Residency Requirement -** Applicants for charity care shall provide the hospital with proof of US citizenship. The applicant shall provide the hospital with any of the identification documents listed in the identification section that contains the applicant's current residence address and a date from which the hospital can reasonably infer that the applicant has resided in the US during the time of service, has no residency in any other country, and has the intent to remain in the State. The hospital may accept an attestation from the applicant that he or she is homeless. If the applicant is unable to provide these documents, the hospital staff shall document why the applicant was unable to comply and issue a determination of ineligible until which time the patient meets one of these requirements for proof of citizenship.
5. **Definitions:**

**A. Assets**: Cash or any item of economic value owned by the patient that can be readily converted into cash. Examples are cash, savings and checking accounts, certificates of deposit, treasury bills, stocks, bonds or other securities, accounts receivable, inventory, equipment, a house (other than primary residence), a car, and other property. For these purposes, assets do not include a primary residence or other property exempt from judgment under Montana law, or any amounts held in pension or retirement plans (although distributions and payments from such plans may be included as family income for purposes of this policy)

**B. Bad Debt Expense**: Uncollectible accounts receivable (where reasonable attempts to collect have been made), excluding contractual adjustments, arising from the failure to pay by patients: (i) whose health care has not been classified as financial assistance care; or (ii) who have qualified for financial assistance in the form of discounted care but have failed to pay the remaining balances due after application of discounts pursuant to this policy.

1. **Family**: The patient, his or her spouse (including a legal common-law spouse), any minor children supported by the patient, and any adults for whom the patient is legally responsible. In the case of a minor patient, family includes both parents, the spouse of a parent, minor siblings, and any adults for whom the patient’s guarantor is legally responsible. If a patient or guarantor has been abandoned by a spouse or parent, that spouse or parent shall not be included as a family member. A pregnant female counts as two family members.
2. **Family Income**: The sum of a family’s annual earnings and cash benefits from all sources before taxes, less payments made for child support. Family income includes gross wages, salaries, dividends, interest, Social Security benefits, workers’ compensation, veterans’ benefits, training stipends, military allotments, regular support from family members not living in the household (other than child support), government pensions, private pensions, insurance, annuity payments, income from rents, royalties, estates, trusts, and other forms of income.
3. **Financial Assistance**: Full reduction in charges to patients for emergency or medically necessary care, in the case of patients who are Financially Eligible, Presumptively Eligible, or Medically Indigent, as those terms are defined in this policy.

1. **Financially Eligible**: A patient whose family income is at or below 250% of the Federal Poverty Guidelines, as set forth in **Exhibit 1** hereto, as of the date of application demonstrated by factual information provided by the patient on the Financial Assistance Application.
2. **Medically Indigent**: A patient who incurs catastrophic medical expenses is classified as Medically Indigent when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system. Patients or guarantors, may be eligible for catastrophic care assistance if they have incurred out of pocket obligations resulting from medical services provided by MVMC that exceed 30% of family income.
3. **Medically Necessary**: Medical necessity will be determined by the treating physician and include (i) Emergency medical services provided in an emergency room setting: (i) Services for a condition, which, if not promptly treated would lead to an adverse change in the individual’s health status, (iii) Non-elective services provided In response to life threatening circumstances in a non-emergency room setting: and/or (iv) Other medically necessary services scheduled in advance and assessed and approved at the discretion of MVMC. Medically necessary services do not include: (i) non-medical services such as social and vocational services; (ii) elective cosmetic surgeries (for these purposes, cosmetic plastic surgery procedures designed to correct appearance for personal reasons are not considered “elective”); (iii) gastric bypass surgeries; (iv) tubal ligations and/or vasectomies; or (v) convalescent care.

In addition, medically necessary does not include deductible and coinsurance associated with medically necessary services provided to patients out of network as defined by their insurers, unless approved in advance by CEO.

1. **Patient:** As applicable depending on context, either the patient or his or her guarantor, *i.e.*, the person having financial responsibility for payment of the account balance.
2. **Presumptively Eligible**: A patient who has not submitted a completed Financial Assistance Application, but who nonetheless is subject to one or more of the following criteria:

* Homeless
* Deceased with no estate
* Mentally incapacitated with no one to act on his or her behalf
* Medicaid eligible, but not on the date of service or for non-covered services
* Enrolled in one or more governmental programs for low-income individuals having eligibility criteria at or below 250% of the Federal Poverty Guidelines
* Incarceration in a penal institution

The Hospital’s trained Financial Service Representatives will routinely review the foregoing criteria with patients, before asking patients to complete the Financial Assistance Application. The Hospital may also utilize other software programs or automated systems to determine Presumptive Eligibility. Patients who meet any of the foregoing criteria for Presumptive Eligibility will be deemed to be eligible for a 100% discount, and will not be asked or required to submit a Financial Assistance Application.

1. **Eligibility for Financial Assistance:**
2. Financial assistance will be given for emergency or medically necessary services to patients who are Financially Eligible or Medically Indigent (in both cases, based on information provided via the Financial Assistance Application (attached as **Exhibit 2**), or to patients who have been determined to be Presumptively Eligible. In addition, financial assistance may be provided in other circumstances on a case-by-case basis as determined by the MMC CEO in his or her discretion.
3. A determination of qualification for financial assistance will cover services provided by the Hospital on an inpatient or outpatient basis. For these purposes, the policy also covers the rendering of professional services by physicians and other providers employed directly by the Hospital as listed on **Exhibit 3**. Any other physicians or providers of care at the Hospital are not subject to this policy and, accordingly, each patient will be responsible for satisfaction or resolution of any bills issued by such physicians or providers for their professional services.
4. Patients seeking financial assistance will be asked to complete the Financial Assistance Application attached as **Exhibit 2** to this policy. Copies of the application form are available at Mountainview Medical Center or online at [www.mvmc.org](http://www.mvmc.org). Applications may be completed directly by the patient, by the patient’s guarantor and/or other legal representative.
5. Patients completing the Financial Assistance Application must return the signed form and required supporting materials through any of the following measures:

* Hand-deliver or Mail to Mountainview Medical Center, PO Box Q/16 W Main St, White Sulphur Springs, MT 59645

Financial Assistance Applications will be considered if received at any time during the 240-day period following the first post-discharge billing statement issued by the Hospital to the patient for such care.

1. Eligibility for financial assistance is conditioned upon (i) the patient’s provision of complete and accurate information on the Financial Assistance Application set forth as **Exhibit 2**, (ii) the patient’s participation in an education session with a Patient Service Representative regarding insurance options available through the Montana Insurance Marketplace (health insurance exchange), Montana HELP, and (iii) the patient’s timely cooperation throughout the financial assistance application process. In connection with determining a patient’s eligibility for financial assistance, the Hospital will not request information other than as described on **Exhibit 2**, although patients may voluntarily provide additional information that they believe to be pertinent to eligibility. If the Hospital contacts the patient to request missing information, the patient will have a period of 30 days to respond. Failure to respond within that 30-day period will result in the Application being suspended from further processing; the patient may re-activate the Application by providing the requested information at any time during the 240-day period following the first post-discharge statement issued by the Hospital to the patient for such care. If a patient provides information that is inaccurate or misleading, he or she may be deemed ineligible for financial assistance and, accordingly, may be expected to pay his or her bill in full.
2. Once a completed Financial Assistance Applicationis received, a review of the application will be done by the CEO for approval.
3. Patients who are uninsured and who do not qualify for financial assistance may contact the Hospital to discuss payment options, including the availability of a payment plan. Financial Service Representatives will inform such patients of any other discounts that may be available under other MMC policies.
4. **Determination and Notification Regarding Financial Assistance:**
5. In the case of patients who are determined to be Financially Eligible, patients with family income at or below 250% of the current Federal Poverty Guidelines (see Exhibit1) as of the date of application, will receive a 100% reduction in the patient portion of billed charges (i.e., full write-off).
6. Patients meeting the criteria of this policy and who are approved for financial assistance will be eligible for free emergent or medically necessary care during the approval period outlined below. Because MVMC does not charge any amount to patients eligible for financial assistance under this policy, MVMC is fully compliant with the amounts generally billed and less-than-gross-charge limitations that apply to charitable hospitals. Please contact a patient service representative at 406-547-3321 if you have any questions.
7. Within 15 business days after submission of a completed Financial Assistance Application, the Hospital will determine whether the patient qualifies for financial assistance based on Financial Eligibility or Medical Indigence and will notify the patient in writing of such determination and the amount of the discount to be provided; if the patient is uninsured, the written notice will indicate that the financial assistance award is conditional upon meeting with a Financial Service Representative to learn about insurance options available through the Montana Health Insurance Marketplace.
8. A determination of financial assistance will be effective for a period of six (6) months from the date the application was approved, for subsequent emergent or medically necessary care, and will include all outstanding accounts receivables, including those at bad debt agencies, unless a payment has been applied on the account. It is the patient’s responsibility to inform MVMC of a change in financial situation or the addition of third-party payer eligibility may alter the approval period and require further review.
9. **Publication:**
10. The existence and terms of this Financial Assistance Policy will be made widely available to residents of the Hospital’s primary and secondary service areas. In furtherance of the foregoing, the Hospital will utilize and widely distribute the plain-language summary attached as **Exhibit 4** to this Policy. Copies of such plain-language summary (i) will be included in patient registration materials and inpatient handbooks, (ii) will be offered to each patient as part of the intake or discharge process, and (iii) will be posted on the Hospital’s website, along with this Policy and the Financial Assistance Application, in a prominent and easily accessible location. This Policy, the plain-language summary, and the Financial Assistance Application will be available in English and any other language that is the primary language of the lesser of (i) 1,000 individuals, or (ii) 5% of the population within the Hospital’s primary and secondary service areas.
11. The Hospital will conspicuously post, in the Patient Admitting and Registration areas as well as the Emergency Department, signage providing information regarding the availability of financial assistance and describing the application process. Such signage will include the following statement: *You may be eligible for financial assistance under the terms and conditions the Hospital offers to qualified patients. For more information, ask your registration or patient service representative for more information.* Such signs will be in both English and any other language that is the primary language of the lesser of (i) 1,000 individuals, or (ii) 5% of the population within the Hospital’s primary and secondary service areas. Such signage will be posted in other areas throughout the Hospital’s facilities offering meaningful visibility.
12. The Hospital will include information on the website of contact information to receive the Financial Assistance Application.
13. **Budgeting, Recordkeeping, and Reporting:**
14. The CEO will ensure that reasonable financial assistance, including both free care and discounted charges, is included in the Hospital’s annual operating budget. The budgeted amount will not act as a cap in providing financial assistance, but will serve as a projection to aid in planning for the allocation of resources.
15. The Hospital will cause completed Financial Assistance Applications (along with required supporting information) to be maintained in the Business Office records. Such records will also reflect information as to whether such Applications were approved or denied.
16. Financial assistance provided by the Hospital pursuant to this Policy will be calculated and reported annually as required under applicable law. Except as otherwise specifically permitted based on context, the Hospital will report its financial assistance provided to qualifying patients under this policy using the cost of services provided (not the charges for the associated services), with cost determined by applying the total cost-to-charge ratio derived from the Hospital’s Medicare cost report.
17. **Confidentiality:**

MVMC recognizes that the need for financial assistance may be a sensitive and deeply personal issue for patients. Confidentiality of information and preservation of individual dignity will be maintained for all who seek financial assistance pursuant to this Policy. No information obtained in the patient’s Financial Assistance Application may be released except where authorized by the patient or otherwise required by law.

**EXHIBIT 1**

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

|  |  |
| --- | --- |
| **2024 Federal Poverty Level** | |
| ***Persons in Family/Household*** | ***250% Federal Poverty Guideline***  ***100% Discount*** |
| 1 | $37,650 |
| 2 | $51,100 |
| 3 | $64,550 |
| 4 | $78,000 |
| 5 | $91,450 |
| 6 | $104,900 |
| 7 | $118,350 |
| 8\*  **\*** Add $13,450 for each additional person above 8 household occupants | $131,800 |

**EXHIBIT 2**

**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 250% 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, Kelsy Borup of patient financial services will be glad to assist you at 406-547-3321.

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

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 including WIC, LIEAP, Food Stamps, etc.
* Evidence of any unemployment or workers compensation payments received in current year -

Any questions regarding the MMC Financial Assistance Program may be directed to Kelsy at:



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.

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.

**FINANCIAL ASSISTANCE APPLICATION**

Family / Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ Tel #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_

Employer’s 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

**\_\_\_\_ 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.

**Exhibit 3**

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Section: Patient Financial Services

Topic: Covered Services

Date Adopted: \_\_\_\_\_\_\_\_\_\_\_ Reviewed:

Last Revision: 06/27/2016

Authorized by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Policy

To clarify covered services rendered for Financial Assistance.

1. Procedure

The Following entities/providers covered for financial assistance:

1. Mountainview Medical Center Inpatient Services
2. Mountainview Medical Outpatient Services (Lab, Radiology, Recurring, ER)
3. All professional service rendered by physicians or other professionals employed by Mountainview Medical Center

Providers: All providers at MVMC participate in the financial assistance program.

***Exhibit 4***

**You may be eligible for Financial Assistance under the terms and conditions the**

**Hospital offers to qualified patients. For more information, ask your clinic registration or**

**Patient Financial Services Representative for more information.**