



**Glendive  
Medical  
Center**

**FINANCIAL ASSISTANCE  
Application Form**

**1. Applicant Information.**

Last Name	First Name	MI	Telephone Numbers: Home	Work	Cell
Street Address			City	State	Zip
Mailing Address (If different form Street Address)			___ Male ___ Female / *Are you pregnant? Yes ___ No ___ .		
Are you:	Homeless?	Yes ___ No ___ .			
	Unemployed?	Yes ___ No ___ .			
	Uninsured?	Yes ___ No ___ .			

**2. If you are applying for someone else, complete this section.**

Last Name	First Name	MI	Relationship to Applicant:		
Street Address			Telephone Numbers: Home	Work	Cell
City	State	Zip	Mailing Address (If different from Street Address)		

**3. Family Information.**

List the people in your family that live with you and you support with your income. Include your spouse, dependent children under age 18, and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child's parent or parents who live with you.

Name of Family Member	Relationship	Date of Birth	Gender	*Pregnant
			M_ F_	Y_ N_
			M_ F_	Y_ N_
			M_ F_	Y_ N_
			M_ F_	Y_ N_
			M_ F_	Y_ N_

**4. Household Member (Non-family)**

Name of Family Member	Relationship	Date of Birth	Gender	*Pregnant
			M_ F_	Y_ N_
			M_ F_	Y_ N_
			M_ F_	Y_ N_

**\*Your unborn child does count as a dependent.**

**5. List Earned Income** before taxes and deductions for each employed household member.

Name of Employed Household Member	Employer Name & Address	Amount Earned	How often? Weekly/Monthly/Annually

**6. Other Income not from an employer.**

Type of Income	Family Member Receiving Income	Amount	How often? Weekly/Monthly/Annually
Social Security			
Railroad Retirement			
Veterans' Benefits			
Retirement Funds			
Annuities			
Pensions			
Child Support			
Alimony			
Unemployment			
Workers Compensation			
Rental Income			
Trust Income			
Disability			
Farm or Self-Employment			
Dividend Income			
Bank Account Income			
Other Income, please specify:			

**7. Liquid Assets**

A. Individual Assets:	_____
B. Family Assets:	_____
C. Assets Include:	
1) Cash	_____
2) Savings Accounts	_____
3) Checking Accounts	_____
4) Certificates of Deposits/I.R.A.	_____
5) Equity in Real Estate (other than primary residence)	_____
6) Other Assets (Treasury Bills, negotiable paper,	

Corporate stocks and bonds	
<b>7) Total</b>	

**8. Other Assets** – If you own any of the following items, please list the type and approximate value.

	Make	Year	Approximate Value	Loan Balance
Home	N/A			
Automobile				
Additional vehicle				
Additional vehicle				
Other property				
<b>Totals:</b>			<b>\$</b> _____	<b>\$</b> _____

**9. Living Expenses.** Fill in standard living expenses shown below.

Payment Type	Recipient Name/Relationship	Amount Paid	How often? Weekly/Monthly/Annually
House Rental/Payment			
Gas/Electricity/Water			
Food Expense			
Other – List Details			

**10. Other Expenses.** Fill in this section if you or anyone in Section 3 is required to make payments for alimony, child support, or personal needs allowance for a family member in a nursing home.

Payment Type	Recipient Name/Relationship	Amount Paid	How often? Weekly/Monthly/Annually
Health Insurance			
Alimony			
Child Support			
Personal Needs Allowance			

**11. Other Insurance.** Uncompensated Care is available for such things as your co-payments and deductibles even if you have other health insurance.

a. Are you covered under any health insurance program? Yes \_\_\_ No \_\_\_ If yes:

Policy Holder (Name)	Insurance Company	Policy number

b. Are you seeking uncompensated care because of a work-related accident or injury? Yes \_\_\_ No \_\_\_

c. Are you seeking uncompensated care because of a car accident? Yes \_\_\_ No \_\_\_

d. Are you a student? Yes \_\_\_ No \_\_\_ If yes, are you full time? \_\_\_ Part time? \_\_\_

e. Do you have an application pending for any of these programs? (Check all that apply)  
 Medicaid \_\_\_ Medicare \_\_\_

f. Are you currently approved for uncompensated care at another hospital or community health center? Yes \_\_\_ No \_\_\_ If yes, where? \_\_\_\_\_

**12. Medical Bills.** Total amount of medical bills is \$ \_\_\_\_\_

Why can't you pay your medical expenses? Why do you need uncompensated care? \_\_\_\_\_

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13. **Assignment of Rights.** Read this section carefully and sign.

I agree to tell this facility about changes to my family status including family size, income and insurance coverage that could change my eligibility for uncompensated care.

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) that may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

I understand that this facility cannot share confidential information with any state or federal agency without my prior approval.

I understand that Uncompensated Care does not cover any Gabert Clinic Providers, Swingbed, or Nursing Home bills I may have incurred.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

If you have questions about this application, contact MarySue Long at (406) 345-3354. Mail your completed application to:

Glendive Medical Center  
Uncompensated Care  
202 Prospect Drive  
Glendive, MT 59330

### Addendum A

**Please answer the questions below. Questions, which are answered “Yes”, must have accompanying documentation.**

- |  |     |    |
|--|-----|----|
| 1. Do you have / have you applied for Medicaid ?   | Yes | No |
| 2. Were you working prior to your Date of Service?   | Yes | No |
| 3. Do you receive Welfare (cash benefits)?   | Yes | No |
| 4. Do you or your spouse receive Unemployment?   | Yes | No |
| 5. Does anyone in your household receive Social Security, or SSI?                                | Yes | No |
| 6. Are you or your spouse receiving a pension?   | Yes | No |
| 7. Do you pay / receive child support? (Circle where appropriate)                                | Yes | No |
| 8. Is someone else supporting you?   | Yes | No |
| 9. Do you and / or your spouse have a checking or savings account?<br>(Circle where appropriate) | Yes | No |
| 10. Do you have any other assets, which may be used to help pay your<br>Hospital debts?          | Yes | No |
| If yes, explain: _____   |     |    |

**Other documentation that MUST be provided.**

- ❖ Two (2) forms of identification for you. One (1) form of identification for your spouse and minor children.
- ❖ Documentation for all questions which you answered, “Yes” to.

Patient’s Signature: \_\_\_\_\_

Spouses Signature: \_\_\_\_\_

## Addendum B

### Documentation Checklist:

- A letter of denial from Medicaid or copies of the Medicaid Card(s)
- Pay stubs from all employers for the last six months, or a letter from your employer as proof of income for the twenty-six week period prior to date of application. A form letter can be provided.
- Most current Income Taxes
- A Benefit Letter from Social Security stating the monthly amount as of date of application.
- Proof of income from any and all sources: support payments, welfare, unemployment, pension, stock dividends, and child support payments. Any other income, which helps with daily living, must be provided.
- Proof of assets: Checking and Savings account statements or a printout from the bank, which covers the date of application.
- Letter from the person supporting you, explaining the situation including their relationship to you, address, length and type of support they provide. A form letter can be provided.
- Two (2) forms of identification (ID) for the patient, one (1) form of ID for all other family members (i.e. Driver's License, Birth Certificate, and Social Security Card).
- Other \_\_\_\_\_

Please provide copies of all requested documents. **Do not send originals through the mail.** If you do not have access to a copier you can bring all the documents to the office and a Financial Counselor will make the copies for you.

If you have any questions, please do not hesitate to call the Business Office, (406) 345-3350.



## RELEASE OF INFORMATION

Date: \_\_\_\_\_

I hereby authorize you to release Employment, Insurance, Income, Bank Account balances, etc., to Glendive Medical Center (GMC). This information will assist me to apply for financial assistance with my hospital bills.

I am aware that this authorization will expire one (1) year from my dated signature.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date