Livingston HealthCare
Billings Clinic Affiliate

320 Alpenglow Lane
Livingston, MT 59047
www.LivingstonHealthCare.org
(406) 222-3541

REQUEST FOR FINANCIAL ASSISTANCE
Hospital

Please complete the application below and return it with all documentation indicated so we may assist you with your financial responsibility to Livingston HealthCare. List all family members you would like to have considered for financial assistance. Please note that financial assistance cannot be considered for any type of elective medical services.

Financial assistance at Livingston HealthCare will be considered for residents of the State of Montana.

Livingston HealthCare cannot guarantee the outcome when applying for financial assistance, but will make every effort to help you resolve your accounts.

Please attach a copy of each of the following:

1. A completed, legible financial assistance application
2. A copy of patient's recent federal income tax return. If married and filing separately, the patient should also supply the spouse's tax return
3. A copy of the three (3) most recent pay stubs if employed or other evidence of income (and spouse's if applicable).
4. Copy of the past three months bank statements (savings and checking)
5. Proof of US citizenship or permanent residence status (i.e. copy of driver's license)
6. An exemption notification from the Marketplace indicating that you were not eligible for assistance for insurance coverage plans offered by the Affordable HealthCare Act (if available)
7. Written verification from public assistance agencies, such as Medicaid, reflecting denials for eligibility (upon request) and as appropriate
8. Written verification of denial for unemployment or worker's compensation benefits (upon request) and as appropriate
9. Reasonable proof of other declared expenses

Patient Name:_____ DOB:_____

Home Address:_____
Street *City* *State* *ZIP*

❑ Own ❑ Rent ❑ Other: *(please explain)*_____

Phone Number:_____(home)_____(work)_____(alt.)

Place of Employment:_____ SSN:_____

Spouse Name:_____ DOB:_____

Spouse Place of Employment:_____ SSN:_____

Dependents:

Name	Age	Name	Age
1.		2.	
3.		4.	
5.		6.	

EXPENSES

Please list all accounts currently owed at Livingston HealthCare:

Patient Name	Balance Owed	Patient Name	Balance Owed

Monthly Expenses:

Mortgage/Rent $_____

Food $_____

Utilities (average) $_____

Phone/Cell Phone $_____

Auto(s) $_____

Personal Loan(s) $_____

Pharmacy $_____

Recreational Loan $_____

Other Medical $_____

Other $_____

Total Monthly Expenses: $_____

INCOME

Monthly Income (gross):

Patient $_____

Spouse $_____

Other Financial Support:

_____ $_____

_____ $_____

_____ $_____

Total Monthly Income: $_____

ASSETS

	Year	Make	Model	Purchase Price	Balance Owed	Estimated Value
Vehicle #1						
Vehicle #2						
Vehicle #3						
Trailer/Camper						
Rec. Vehicle						
Other:						
Other:						
Other:						

Account Name	Current Balance	Account Name	Current Balance
Checking		Stocks	
Savings		Bonds	
		CDs	

Retirement Funds:

IRA:_____

401K:_____

403B:_____

Other:_____

Total Assets: $_____
(Please include estimated value of vehicles.)

If you have any questions, please contact a patient financial services representative at (406) 823-6414.

Signature:_____ **Date:**_____

Please return this application with all required documentation to:

Livingston HealthCare Financial Counselor
320 Alpenglow Lane
Livingston, MT 59047