

Personal Financial Statement (*Confidential*)

**\*\*In order for MDMH to consider your application, all sections of the application must be complete\*\***

I authorize the access and use of any and all information stored with Marcus Daly Memorial Hospital Corporation, including my protected health information (PHI) and personal financial information by the Marcus Daly Memorial Hospital Financial Assistance Committee. I understand that this information may be used in the decision making process regarding my qualification for financial assistance. In addition, your signature also authorizes Marcus Daly Memorial Hospital and Daly Foundation to verify information provided in this financial statement and to obtain a Credit Report.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Spouse's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>Name:</b>	SSN:	DOB:
<b>Spouse's Name:</b>	SSN:	DOB:
Mailing Address:	City/State:	Zip Code:
Physical Address:	City/State:	Zip Code:
Daytime Telephone #	Evening Telephone #	

<b>Applicants Employer:</b>	Position:	Date of Hire:
Average hours worked per week:	If unemployed, last date worked:	
If unemployed and/or not working full-time (32-40 hours per week), please explain why:		
<b>Spouse's Employer:</b>	Position:	Date of Hire:
Average hours worked per week:	If unemployed, last date worked:	
If unemployed and/or not working full-time (32-40 hours per week), please explain why:		

<b>Number of Dependents:</b>	Ages:
Name of Dependents (First & Last Name):	
<i>MONTANA RESIDENTS: If you are within income guidelines for Healthy Montana Kids, all children must have health insurance coverage.</i>	

Are you covered by any insurance? (Check one box)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If uninsured, have you applied for insurance through healthcare.gov (Montana Healthcare Exchange)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If no, why?		
Have you applied for Medicaid benefits or have you been screened for Medicaid benefits? (Required for this application process if you are uninsured)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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

<b>GROSS MONTHLY INCOME</b>	<b>(BEFORE TAXES AND DEDUCTIONS)</b>	
<b>Source</b>	<b>Self</b>	<b>Spouse</b>
Employment	\$	\$
Commissions/Bonuses/Tips	\$	\$
Unemployment/Workman's Comp	\$	\$
SSI or SSDI	\$	\$
Child Support	\$	\$
Retirement/Pension	\$	\$
Other (describe)	\$	\$
<b>Total</b> <i>(before taxes and deductions)</i>		

<b>ASSETS</b>	
<b>CASH ON HAND</b>	\$
<b>CHECKING ACCOUNT BALANCE</b> <i>Provide current statement(s) showing value/balances for all accounts.</i>	\$
<b>SAVINGS ACCOUNT BALANCE</b> <i>Provide current statement(s) showing value/balances for all accounts.</i>	\$
<b>STOCKS/BONDS/IRA/RETIREMENT/ETC.</b> <i>Provide statement(s) showing value/balances.</i>	\$
<b>CASH VALUE OF LIFE INSURANCE</b>	\$
<b>AUTO 1</b> <b>Year/Make:</b> <b>Model:</b>	<b>Current Value: \$</b>
<b>AUTO 2</b> <b>Year/Make:</b> <b>Model:</b>	<b>Current Value: \$</b>
<b>HOME/PROPERTY</b> <b>Purchase Date:</b> ____ / ____ / ____	<b>Purchase Price: \$</b>  <b>Current Value: \$</b>
<b>OTHER PROPERTY (DESCRIBE)</b>	<b>Current Value: \$</b>
<b>RECREATIONAL MERCHANDISE (DESCRIBE)</b>	<b>Current Value: \$</b>
<b>OTHER ASSETS (DESCRIBE)</b>	<b>Current Value: \$</b>

EXPENSES / LIABILITIES	MONTHLY PAYMENTS	ACCOUNT BALANCE
<b>Mortgage/Rent</b> <i>(If no mortgage or rent expense, please explain why)</i>	\$	\$
<b>Food</b>	\$	\$
<b>Do you receive SNAP benefits?</b>	<b>YES / NO (circle one)</b>	<b>If yes, amount per month \$ _____</b>
<b>Utilities</b>	\$	\$
<b>Prescriptions</b>	\$	\$
<b>Insurance</b>		
<b>Health</b>	\$	\$
<b>Auto</b>	\$	\$
<b>Other (specify)</b>	\$	\$
<b>Auto Loan 1</b>	\$	\$
<b>Auto Loan 2</b>	\$	\$
<b>Telephone</b>		
<b>Home</b>	\$	\$
<b>Cell</b>	\$	\$
<b>TV/Cable/Internet</b>	\$	\$
<b>Personal Loan (specify)</b>	\$	\$
<b>Other expenses (specify)</b>	\$	\$
<b>MEDICAL (LIST EACH)</b>	<b>MONTHLY PAYMENTS</b>	<b>ACCOUNT BALANCE</b>
<b>MDMH</b>	\$	\$
	\$	\$
	\$	\$
	\$	\$
<b>CREDIT CARDS (LIST EACH)</b>	<b>MONTHLY PAYMENTS</b>	<b>ACCOUNT BALANCE</b>
	\$	\$
	\$	\$
	\$	\$
	\$	\$
<b>CALCULATE</b>	<b>TOTAL Monthly Payments</b>	<b>TOTAL Account Balance</b>
<b>Total Expenses / Liabilities</b>	\$	\$

**ADDITIONAL INFORMATION**

By filling out this financial assistance application you are indicating that you are unable to meet the Hospital's payment requirements for your account(s). In some cases we are able to consider reduced payments and/or balance reductions.

Please indicate what type of financial assistance you are applying for (check one):

- Reduced Monthly Payment or  Reduction of Balance Owed

If you reported zero income please *describe in detail*

- How you pay the expenses listed on the financial assistance application and all other daily living expenses, and
- Why you are not working and your efforts in searching for employment.

You may use the back side of this form if additional space is needed for explanation.

If someone assists with your living expenses, *provide documentation for the amounts received.*

If you did not file a Federal Tax Return, please explain why.

If total expenses exceed income reported, please describe how expenses are met.

**REQUIRED DOCUMENTATION CHECKLIST**

- Completed financial assistance application
- Complete copy of *most current* Federal tax return (**including schedules and attachments**)
- Current copy of statement(s) for all banking and savings accounts
- Current copy of statement(s) for all Stocks/Bonds/IRA/Retirement/Etc.
- Year-to-date proof of **ALL** income (current pay stubs for last 3 months, unemployment, child support, social security income, disability income, etc.)
- Documentation regarding Medicaid denial or approval

**Applications without complete and required documentation will be returned.**

**Please return your Financial Assistance Application in a timely manner.** The financial assistance committee only meets once per month. Normal billing and collections will continue through the financial assistance application process. If you need help filling out the application or have questions please call the Patient Financial Service Rep at (406) 375-4444.

**Return completed application to:  
Marcus Daly Memorial Hospital  
ATTN: PATIENT ACCOUNTS  
1200 Westwood Drive  
Hamilton, MT 59840**