



**CLARK FORK VALLEY MEDICAL SERVICES
APPLICATION FOR FINANCIAL ASSISTANCE**

Clark Fork Valley Hospital offers a Financial Assistance Program for those patients who are unable to satisfy their personal financial responsibility for health care services provided at the hospital. The application form must be completed and submitted with income documentation, in the form of pay stubs and/or income tax returns. All information on the application and support documentation is kept confidential and utilized only in the evaluation process. Financial Assistance is extended based on household size and provided for members of households qualifying with income up to 250% of the Federal Poverty guidelines on a sliding scale. If a percentage discount is approved under the Financial Assistance Program, we do require a payment agreement on the remaining balance. The hospital's Financial Specialists are eager to assist our patients with the program application and to help identify resources to satisfy their bills.

If you have any questions, please contact the Financial Coordinator at 826-4859. Your cooperation is appreciated.

PATIENT ACCT #: _____ DATE: _____

PATIENT NAME: _____ SPOUSE: _____

MAILING ADDRESS: _____

PHYSICAL ADDRESS (if different): _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ SPOUSE'S EMPLOYER: _____

OF IN HOUSEHOLD-ADULTS: _____ CHILDREN: _____

MONTHLY INCOME:\$ _____ SPOUSE'S INCOME:\$ _____

SOCIAL SECURITY:\$ _____ PENSION:\$ _____

OTHER (child support, rental income, etc.): \$ _____

TOTAL MONTHLY INCOME: _____

MONTHLY EXPENSES: RENT/MORT. PAYMENT:\$ _____ POWER:\$ _____

TELEPHONE:\$ _____ OTHER:\$ _____

	<u>TO WHOM</u>	<u>MONTHLY PMT</u>	<u>BALANCE</u>
LOANS/CHARGE ACCOUNTS:	_____	_____	_____
MEDICAL BILLS:	_____	_____	_____
OTHER	_____	_____	_____

INSURANCE EXPENSE (House/Auto/Life):\$ _____

HEALTH INSURANCE PREMIUMS (monthly):_____

AUTO EXPENSE (Gas/License): \$ _____ PROPERTY TAX: \$ _____

GROCERIES: \$ _____

CREDIT CARDS:	BALANCE	MONTHLY PAYMENT	AVAILABLE CREDIT

OTHER EXPENSES: \$ _____
(Please Itemize These) _____

ASSETS

REAL ESTATE: HOUSE: \$ _____ LOCATION: _____

LAND: \$ _____ LOCATION: _____

BALANCE OF OWING LIENS: _____

VEHICLES: YEAR _____ MAKE _____
YEAR _____ MAKE _____

RV/BOAT/TRAILER: YEAR _____ MAKE _____

CHECKING ACCOUNT	\$ _____	BANK _____
SAVINGS ACCOUNT	\$ _____	BANK _____
CERTIFICATES OF DEPOSIT	\$ _____	BANK _____
CREDIT UNION	\$ _____	BANK _____
CASH VALUE OF LIFE INS.	\$ _____	BANK _____
OTHER INVESTMENTS	\$ _____	BANK _____

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

SIGNATURE: _____ DATE _____

SIGNATURE: _____ DATE _____