

Senior Care is a benefit program developed by Clark Fork Valley Hospital (CFVH), specially designed to meet the needs of our patients age 65 or over. This program provides the following:

- ♥ Personalized Senior Care Identification Card to streamline hospital admission and discharge
- ♥ Personal billing and financial assistance with medical bills
- ♥ A complimentary guest tray daily during your stay as an inpatient at CFVH
- ♥ Discounted meals in the CFVH cafeteria
- ♥ Special events and educational opportunities, as scheduled
- ♥ Waiver of any remaining balance of Medicare deductibles and coinsurance after billing to Medicare and secondary insurance. Discounts vary depending on income level and sliding scale. (See Sliding Scale reference)
- ♥ Discounted purchases at Mementos Gift Shop located at the main hospital entrance lobby



Providing the assistance you need so you can enjoy your health rather than stress about it...

Senior Care ENROLLMENT FORM

NAME: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

HOME PHONE: _____ SOCIAL SECURITY #: _____

MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

SPOUSE'S NAME (IF APPLICABLE): _____

YOUR PRIMARY CARE PROVIDER'S NAME: _____

WHERE WERE YOU LAST HOSPITALIZED? _____

INSURANCE INFORMATION

MEDICARE #: _____ PART A (HOSPITAL) PART B (PHYSICIAN)

MEDICAID: YES (ID #: _____) NO

OTHER INSURANCE

CO. NAME: _____ POLICY #: _____

CO. NAME: _____ POLICY #: _____

ANNUAL INCOME (DO NOT INCLUDE SOCIAL SECURITY)

PLEASE CHECK ONE BOX:

- | INDIVIDUAL | COUPLE |
|--|--|
| <input type="checkbox"/> UNDER \$10,000 | <input type="checkbox"/> UNDER \$14,000 |
| <input type="checkbox"/> \$10,001 - \$15,000 | <input type="checkbox"/> \$14,001 - \$21,000 |
| <input type="checkbox"/> \$15,001 - \$18,200 | <input type="checkbox"/> \$21,001 - \$24,500 |
| <input type="checkbox"/> \$18,201 - \$26,000 | <input type="checkbox"/> \$24,501 - \$35,000 |
| <input type="checkbox"/> OVER \$26,000 | <input type="checkbox"/> OVER \$35,000 |

APPLICANT'S SIGNATURE: _____

DATE: _____

PLEASE RETURN TO: CFVH . PO BOX 768 . PLAINS, MT 59859 OR ANY FAMILY MEDICINE NETWORK OFFICE