FALLON MEDICAL COMPLEX
"Friends Healing Friends"

PO Box 820
202 South 4th Street West
Baker, MT 59313-0820
(406) 778-3331
FAX (406) 778-2488
www.fallonmedical.org

Patient Care Financial Assistance

It is the policy of Fallon Medical Complex (FMC) as a non-profit charitable organization to provide health care to all persons in our community, including those with an inability to pay for those services. Our Financial Assistance Program (FAP) is designed to provide assistance to responsible parties who desire to pay for their medical services but who do not have the financial ability to do so. It is a community service, and as such, may be denied if charges were incurred while participating in any type of illegal activity. This program is intended to be the last option for payment after exhausting all other alternatives.

Financial assistance will be considered for FMC account balances no more that 12 months in arrears or 60 days beyond the date of the application. FMC must pre-approve any charges within the 60 days post application date. FMC may consider older balances at their discretion.

To this end, responsible parties seeking financial assistance may apply for relief from FMC through submittal of the following items for their household **(all individuals living in the household, including those not legally related to you):**

1. Completion of the attached Financial Statement.
2. Proof of income as stated in the Financial Statement, as follows:
   a. Payroll check stubs or other monthly income sources for the last three (3) months for all persons in your household (whether legally related to you or not).
   b. A copy of your most recently completed calendar year IRS tax return with supporting schedules.
   c. Three months of all bank account statements
   d. A copy of your bank financial report, if you are a business owner, farmer, rancher, etc.
3. Notice of ineligibility from other assistance programs such as Medicaid, SSI/SSDI, Crime Victims Assistance, Health Insurance Marketplace, etc.
4. Notice of ineligibility for unemployment or worker's compensation benefits, as appropriate.
5. A statement detailing your need for financial assistance, including a detail of other medical bills owed.

The items listed above must be returned to Fallon Medical Complex Business Office within thirty (30) business days of receiving this application. If circumstances prevent you from returning this application within that time frame, please contact the Business Office Manager. An incomplete application may result in a denial or a written request for additional information. We will notify you of a final determination within thirty (30) calendar days of our receipt of your completed application.

FMC will provide personal assistance in understanding our FAP and will assist any responsible party in completing this application if requested.

All information submitted as a part of this application will be kept confidential.

Financial Statement

1. **Applicant** _____ Spouse's Name _____

Address _____
Number and Street City State Zip Code

Telephone ( ) _____ Cell Phone ( ) _____ E-Mail Address _____

2. **Occupation** (self) _____ Social Security No. _____

Employer _____
Name Address Phone Number

Occupation (spouse) _____ Social Security No. _____

Employer _____
Name Address Phone Number

3. Number of Members Residing in Household (Please list first and last name).

Name	Relationship	Age

4. Please list Name(s) of Patient(s) and Date(s) of Service (Add an attached page if necessary.)

Patient Name _____ Date (s) of Service _____
Patient Name _____ Date (s) of Service _____

5. Income : List All Income For Household	**For Last 3 Months**	**For Last 12 Months**
Wages (Gross Income before Taxes)	$	$
Farm or Self-Employed		
Public Assistance ☐ Food Stamps ☐ GA ☐ AFDC ☐ Other		
Social Security /Supplemental Security (SSI)		
Unemployment Compensation		
Worker's Compensation		
Alimony &/or Child Support		
Military Family Allotments		
Pensions/Retirement		
Income from Dividends, Interest, Rent, Etc.		
Income from Sale of Property		
Education Grants/Loans		
Inheritance		
Royalties		
Native American Income Monies		
Income Tax Refund ☐ Federal ☐ State		
Settlement Income ☐ Worker's Compensation ☐ Bodily Injury ☐ Lawsuit ☐ Other		
Other Income (please explain) _____		
TOTALS:	$	$

Additional Information

What is the amount of monthly payment you are able to make?

If you are not able to provide the information on this application or proof of income, please explain.

If you have no income, please explain how you meet your daily expenses.

If you annual household income has increased or decreased from the past year, please explain the circumstances.

Please provide any additional information that you think will help us to understand your situation and why we should approve financial assistance on your behalf.

For more information or assistance, please contact the FMC Business Office Manager at 406.778.3331, Ext 115 or the FMC Social Worker at 406.778.3331 Ext 203 during the business hours of Monday-Friday, 8AM -5PM.

If you would you like assistance in applying for discounted insurance via the Insurance Marketplace, please contact our Marketplace Navigator at 406.778.3331, Ext 199.

PLEASE RETURN COMPLETED APPLICATIONS TO:

In Person:
Fallon Medical Complex
Business Office Manager
Clinic Entrance
202 South 4th Street West
Baker, Montana

By Mail:
Fallon Medical Complex
Attn: Business Office Manager
PO Box 820
Baker, MT 59313

PLEASE READ CAREFULLY

I authorize a representative of Fallon Medical Complex to obtain personal, financial or medical information from any source deemed necessary to determine an acceptable financial agreement and/or assisting me in obtaining financial assistance. In so authorizing, I release any person(s) or business from any or all liability connected with said release.

I will make application for assistance (Medicaid, Medicare, Insurance through the Marketplace, etc.) which may be available for payment of my medical expenses and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the facility the full amount recovered.

I request that Fallon Medical Complex make a written determination of my eligibility for uncompensated services a Fallon Medical Complex. I understand that the information which I submit concerning my annual income and number of residents in my household is subject to verification to Fallon Medical Complex. I understand that if the information which I submit is determined be untrue, such a determination will result in a denial of financial assistance, and that I will be liable for charges for services provided.

_____ _____

Signature Date of Request

_____

Spouse Signature

HAVE YOU ENCLOSED THE FOLLOWING?

- Payroll check stubs for last 3 months ☐
- Bank statements for previous 3 months ☐
- Notice of ineligibility from Medicaid, SSI/SSDII, crime victims, workers compensation, or unemployment as appropriate ☐
- Copy of latest Federal (IRS) income tax return ☐
- Answered all questions detailing need for assistance ☐
- Other data necessary to determine your eligibility ☐