No Staples

Vista Plains HEALTH

Financial Assistance Application

Questions? Use the QR code on the right or go to vistaplains.org. Call Patient Financial Services at (406) 238-2601 or 1 (800) 332-7156, x2601.

1) Applicant/Responsible Party:

Name (first, middle, last): _____ Date of Birth: _____

Address: _____ Phone #: _____

2) Spouse/Partner:

Name (first, middle, last): _____ Date of Birth: _____

3) Family Members:

Please list other family members whom you financially support (*provide more than 50% of living expenses for 1 year*):

	Name	Date of Birth	Relationship to Applicant
1)			
2)			
3)			
4)			

*if more than 4, please list members on an additional page.

4) *Financial Assistance for services obtained in locations other than Wheatland Memorial Hospital require a separate application.*

5) Public Assistance Benefits:

Are you currently receiving benefits from any of the following programs? *If so, you may automatically qualify for 100% financial assistance*. Please check all that apply.

Include documentation of your confirmation/eligibility in the following program(s) with your application:

- ☐ SNAP - Supplemental Nutrition Assistance Program
- ☐ WIC - Women, Infants, & Children Supplemental Nutrition Program
- ☐ Subsidized/Low Income Housing or Rental Assistance
- ☐ Low Income Energy Assistance Program (LIEAP)
- ☐ Low Income Prescription Programs
- ☐ Homeless or receiving care from a homeless shelter, clinic, or center

STOP

If you checked any boxes on the left, skip to Section 9 to sign and date form.

Please include program documentation to complete the application.

6) Retired/Social Security Applicants:

Does your household have any other income source besides social security and/or disability?

Yes ☐ No ☐ → STOP

If you answered "No", skip to Section 9 to sign and date form. *Please include your most recent bank statements to complete the application.*

If "Yes", please move to the next section on page 2.

7) Employment Status:

	Employed	Unemployed	Self Employed	Retired	Disabled	Student	Other income
Please write your answers in boxes	Employer name & length of time with employer	Length of unemployment	Type of self-employment	Type of retirement (Soc Sec, IRAS, pension, etc.)	Length of disability	School attending	Type of other income (rental income, interest, dividends, etc.)
Applicant							
Spouse/Partner							
Required documentation for each applicable box above →	Include last 3 months of pay stubs including year to date detail	Include unemployment award letter	Include current 'year-to-date' profit/loss statement	Include 1099s for social security, pensions, retirement, etc.	Include disability award letter from Federal or State govt and/or private insurer	N/A	Include Federal tax return, including all supporting schedules

REQUIRED DOCUMENTATION FOR ALL APPLICANTS:	1) Include previous year's Federal tax return, including all supporting schedules	2) if you do not have the required supporting documents, please provide a letter of explanation	**Your financial assistance application will not be processed until all required documents are received**

8) Health Insurance Information:

Please check as many boxes as apply:

☑ I have health insurance.
Company/Plan Name for Applicant:_____
Company/Plan Name for Spouse/Partner:_____

☐ Health insurance is available to me, but I have declined or opted out.
Reason for declining/opting out Applicant:_____
Reason for declining/opting out Spouse/Partner:_____

☐ Payments are available to Applicant or Spouse/Partner through Health Share.

☐ Other:_____ Spouse/Partner:_____

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9) Release of Information and Attestation for Financial Assistance:

For *ALL APPLICANTS*

I certify that the information I have provided is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services provided by Vista Plains Health only. I give permission to Billings Clinic and all affiliated clinics, hospitals, and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Billings Clinic representatives to investigate the information contained herein.

Signature of Applicant (Patient, Parent, or Guardian): Date:

Signature of Spouse/Partner: Date:

Please mail your application and documentation to:
Billings Clinic
Attn: Financial Assistance
PO Box 35100
Billings, MT 59107
Question? (406) 238-2601