

Patient Financial Assistance Application  
Madison Valley Medical Center and Rural Health Clinic

Madison Valley Medical Center and Rural Health Clinic (MVMC) provides, within the limits of its resources, primary, secondary and long term care regardless of race, religion, age, sex or ability to pay.

Financial assistance is available based upon ability to pay.

Ability to pay is determined based upon published Federal Poverty Guidelines (FPG). For individuals or families with income at or below the FPG, 100% discount may be available. Discounts up to 20% are available for individuals and families with income up to 250% of the FPG income level. A 10% prompt payment discount on service not paid by Medicare and other third party insurance coverage is available to everyone with income in excess of 250% of the FPG. FPG guidelines are updated in February of each year.

Financial assistance from MVMC is applied after consideration of all other potential third party sources, including Medicaid.

Qualification for financial assistance from MVMC is determined from an application completed by the patient or responsible guarantor. A completed application with required documentation will be promptly reviewed by the Patient Business Service personnel of MVMC. The applicant will be notified in writing of their eligibility status. If an applicant appears to be eligible for Medicaid, the Medicaid expansion, or other governmental assistance the applicant will be required to submit an application to those programs for assistance. If other assistance is denied, then the patient's financial assistance application will be reviewed for eligibility by management. A written denial from that agency will qualify as additional support for MVMC providing financial assistance coverage. Final approval will be granted or denied by MVMC's CEO. Any special considerations will be taken into account on a case by case basis.

The following services are not subject to financial assistance:

- Cosmetic Services
- Elective Services
- Birth control pills or other contraceptive devices
- Diagnostic testing or services received at other facilities
- Non-Diagnostic testing not required for medical purposes
- Professional fees or services charged by providers that are not billed by MVMC

To determine if you might qualify for financial assistance, please refer to the MVMC assistance qualification matrix. Find your family size in the first column and your annual family income in that row. The discount you may be eligible for is found at the top of the column in which your annual income is found. For example, a family of four with an

annual income of \$42,000 could qualify for a 50% discount on their portion of the qualifying service charges at MVMC.

To apply for financial assistance, please complete the attached application and include the appropriate proof of income documentation. If you need help in completing the application process, a member of our Patient Business Service staff will be glad to assist you. Your completed application can be accepted by any member of the Patient Business Service staff.

All approved applications are subject to update and review every six months.

Please include the following applicable documentation with your application:

- Copy of your most recent filed federal income tax return
- Current year to date pay records or written verification of wages from your employer
- Social Security Income, including SSI payments for dependents
- Child support payments received for current year
- Any evidence of public assistance or denial of public assistance
- Evidence of any unemployment or worker's compensation payments received in current year
- Written verification from public assistance approving or denying assistance

Any questions regarding the MVMC Financial Assistance Program may be directed to the Patient Business Service Staff at:



Madison Valley Medical Center  
305 N Main Street  
Ennis, MT 59729

(406) 682-6842

Madison Valley Medical Center and Rural Health Clinic offer assistance to patients that would otherwise be unable to obtain medical care due to financial hardship through our Financial Assistance Program.

All assistance is based on total income and family size. *A family unit is defined as legally married persons and dependent minor children or as dependents listed on a federal income tax return.*

You must fill out an application and supply all necessary documents to be considered for this program. MVMC must be provided enough documentation to determine if your family income falls within the FPGs as well as rule out any other government assistance programs. If approved, the program lasts for a six-month period; after which, a patient must reapply with updated financial information.

To be eligible, you must first exhaust all possible insurance coverage, Medicare, Medicaid or any third party payment sources. You must have proof of denial/ acceptance if you could possibly be eligible for Medicaid or other assistance programs. The Financial Assistance program can be used with or without an insurance program if you are not eligible for one.

You must provide proof of income, government benefits such as unemployment and other income such as child/ spousal support. **The most recent Tax Return is the preferred proof of income.** If this is unavailable, MVMC reserves the right to request further information as needed to verify potential income.

<b>2019 POVERTY GUIDELINES</b>										
<b>Family Size</b>	100%	90%	80%	70%	MCAID EXP.	60%	50%	40%	30%	20%
1	\$12,490	\$14,364	\$15,613	\$16,862	<b>\$17,236</b>	\$18,735	\$21,858	\$23,107	\$24,980	\$31,225
2	\$16,910	\$19,447	\$21,138	\$22,829	<b>\$23,336</b>	\$25,365	\$29,593	\$31,284	\$33,820	\$42,275
3	\$21,330	\$24,530	\$26,663	\$28,796	<b>\$29,435</b>	\$31,995	\$37,328	\$39,461	\$42,660	\$53,325
4	\$25,750	\$29,613	\$32,188	\$34,763	<b>\$35,535</b>	\$38,625	\$45,063	\$47,638	\$51,500	\$64,375
5	\$30,170	\$34,696	\$37,713	\$40,730	<b>\$41,635</b>	\$45,255	\$52,798	\$55,815	\$60,340	\$75,425
6	\$34,590	\$39,779	\$43,238	\$46,697	<b>\$47,734</b>	\$51,885	\$60,533	\$63,992	\$69,180	\$86,475
7	\$39,010	\$44,862	\$48,763	\$52,664	<b>\$53,834</b>	\$58,515	\$68,268	\$72,169	\$78,020	\$97,525
8	\$43,430	\$49,945	\$54,288	\$58,631	<b>\$59,933</b>	\$65,145	\$76,003	\$80,346	\$86,860	\$108,575
For Family Units of more than 8 members, add \$4,420 for each additional member.										
%FPG	100%	115%	125%	135%	138%	150%	175%	185%	200%	250%

You must fall within the poverty income guidelines established by the federal government as shown below. *For example: a four-person family with an income of \$42,000 could qualify for 50% assistance.*

FINANCIAL ASSISTANCE APPLICATION

Family / Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Tel # \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Employers name and address: \_\_\_\_\_  
Social Security Number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Total number in household: \_\_\_\_\_

List all members of your immediate family living in your household. Please include their date of birth.

1. \_\_\_\_\_ DOB \_\_\_\_\_ 2. \_\_\_\_\_ DOB \_\_\_\_\_  
3. \_\_\_\_\_ DOB \_\_\_\_\_ 4. \_\_\_\_\_ DOB \_\_\_\_\_  
5. \_\_\_\_\_ DOB \_\_\_\_\_ 6. \_\_\_\_\_ DOB \_\_\_\_\_

Please check any of the following circumstances listed below that apply to you:

\_\_\_\_\_ I am not eligible for Medicaid, Medicare or other third party assistance.  
\_\_\_\_\_ I cannot afford private health insurance.  
\_\_\_\_\_ I am not able to afford the cost of my health care at this time.

List all sources of monthly income:

Employment and tips \$ \_\_\_\_\_ Unemployment compensation \$ \_\_\_\_\_  
Food Stamps \$ \_\_\_\_\_ Child Support / Alimony \$ \_\_\_\_\_  
Pension \$ \_\_\_\_\_ Social Security \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_ Total Gross Income \$ \_\_\_\_\_

List all household Savings and Checking accounts.

Institution 1: \_\_\_\_\_ Institution 2: \_\_\_\_\_  
Institution 3: \_\_\_\_\_ Institution 4: \_\_\_\_\_

Total balance of all Savings Accounts: \_\_\_\_\_  
Total balance of all Checking Accounts: \_\_\_\_\_

List all other assets. This can include stocks, land, trusts, retirement accounts, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*MVMC may require proof of assets in order to assess their value.

By affixing my signature below, I \_\_\_\_\_, attest that the information given above is a true representation of my financial situation. I acknowledge that verification in writing may be required.

\_\_\_\_\_ Date \_\_\_\_\_  
Applicant or Family Representative

## Request for Financial Assistance Checklist

Please provide all documents requested within 14 business days. Failure to return the application and/ or required documents could result in your request being denied. If you have any questions please call 406-682-6842

\_\_\_ COPY OF RECENT TAX RETURNS ( INCLUDING SCHEDULE C IF SELF EMPLOYED)

\_\_\_ COPY OF DENIAL LETTER FROM MT MEDICAID IF APPLICABLE

\_\_\_ PROOF OF PRIMARY INSURANCE COVERAGE IF APPLICABLE

\_\_\_ SIGNED AND DATED APPLICATION WITH ALL FAMILY MEMBERS LISTED

If you did not file 2018 taxes or feel that your current financial situation is not reflected in the tax information, please return the applicable following in *addition* to your tax return. Please note that further information may be required if proof of income cannot be determined by information provided.

\_\_\_ SAVINGS ACCOUNT STATEMENT FOR THE LAST 3 MONTHS

\_\_\_ CHECKING ACCOUNT STATEMENT FOR THE LAST 3 MONTHS

\_\_\_ PROOF OF RECENT IRA/401K/PENSION STATUS

\_\_\_ PAY STUBS FOR THE LAST MONTH

\_\_\_ PROOF OF UNEMPLOYMENT

\_\_\_ PROOF OF DISABILITY

MVMC business office is available to assist in filling out applications related to Montana state programs, HMK, HMK Plus or Financial Assistance. Our Navigator can assist you with applying for insurance via the Federal Insurance Exchange during the open enrollment period each year. Assistance applying for the Medicaid Expansion is available year round. You have the right to a copy of this form after you sign it.