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, medical 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. FPG guidelines are updated in February of each year.

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. 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.

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

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. The Financial Assistance program can be used with or without an insurance program if you are not eligible for one.

			2023 POVERTY GUIDELINES							
Family Size	100%	90%	80%	70%	MCAID EXP.	60%	50%	40%	30%	20%
1	14,580	16,767	18,225	19,683	20,120	21,870	25,515	26,973	29,160	36,450
2	19,720	22,678	24,650	26,622	27,214	29,580	34,510	36,482	39,440	49,300
3	24,860	28,589	31,075	33,561	34,307	37,290	43,505	45,991	49,720	62,150
4	30,000	34,500	37,500	40,500	41,400	45,000	52,500	55,500	60,000	75,000
5	35,140	40,411	43,925	47,439	48,493	52,710	61,495	65,009	70,280	87,850
6	40,280	46,322	50,350	54,378	55,586	60,420	70,490	74,518	80,560	100,700
7	45,420	52,233	56,775	61,317	62,680	68,130	79,485	84,027	90,840	113,550
8	50,560	58,144	63,200	68,256	69,773	75,840	88,480	93,536	101,120	126,400
For Family Units of more than 8 members, add $4,720 for each additional member.										
%FPG	100%	115%	125%	135%	138%	150%	175%	185%	200%	250%

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 __________

List all sources of monthly income:

Employment and tips	$_________	Unemployment compensation	$_________
Child Support	$_________	Alimony	$_________
Pension	$_________	Social Security	$_________
Other	$_________	Total Gross Income	$_________

MVMC must verify your total household income in order to qualify you for our financial assistance program. One or more of the following document types may be required for this purpose:

- Most recent year's tax return
- W-2 Withholding Statements
- Proof of recent IRA/401K/Pension Status
- Pay Stubs for the last month
- Proof of Unemployment
- Proof of Disability

Other documentation may be required or accepted based on household financial circumstances and approval of MVMC Business Office Representative.

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.

_________________________________ ________________
Applicant or Family Representative Date

*Any questions regarding the MVMC Financial Assistance Program may be directed to the Patient Business Service Staff at 406-682-6602 or pt.financial.svc@mvmedcenter.org.