



**Roosevelt Medical Center**

PO Box 419  
 818 2nd Ave. East  
 Culbertson, MT 59218  
 406-787-6401  
[www.rooseveltmedical.org](http://www.rooseveltmedical.org)

## GUIDE TO FINANCIAL ASSISTANCE

For Services Provided By  
 Roosevelt Medical Center and Roosevelt Medical Clinic

### PAYMENT OPTIONS

At Roosevelt Medical Center, we understand that healthcare expenses may occur when you least expect them and can create a financial burden for you and your family. To assist you through the payment process, Roosevelt Medical Center offers a variety of payment options that are individualized for your needs.

### FINANCIAL ASSISTANCE

Roosevelt Medical Center offers financial assistance to individuals who need help with their medical expenses. The process requires completing the attached family assistance plan application. Eligibility is based on income and size of household.

Annual Income \*

Family Size	Percentage that may be adjusted from your bill				
	100%	75%	50%	25%	0%
1	\$13,590	\$20,385	\$27,179	\$27,180	\$27,181
2	\$18,310	\$27,465	\$36,619	\$36,620	\$36,621
3	\$23,030	\$34,545	\$46,059	\$46,060	\$46,061
4	\$27,750	\$41,625	\$55,499	\$55,500	\$55,501
5	\$32,470	\$48,705	\$64,939	\$64,940	\$64,941
6	\$37,190	\$55,785	\$74,379	\$74,380	\$74,381
7	\$41,910	\$62,865	\$83,819	\$83,820	\$83,821
8	\$46,630	\$69,945	\$93,259	\$93,260	\$93,261

To determine your initial eligibility please refer to the chart on the right. Find the size of your family in the left hand column and look across to see where your total household income falls.

Elective services are excluded from the financial assistance program. Please see the interest free extended payment plan.

\* The complete sliding fee schedule is on the application form.

### Interest Free Extended Payment Plan

Roosevelt Medical Center offers an interest free payment plan for up to 24 months. Typically a \$50 minimum payment is required.

If your Balance is		# of Monthly
	to	Balance in full
\$1.00	\$100.00	
\$100.01	\$600.00	6
\$600.01	\$1,200.00	12
\$1,200.01	\$2,400.00	15
\$2,400.01	\$3,000.00	18
\$3,000.01	\$4,000.00	21
\$4,000.01	and up	24

### Medicaid & the Children's Health insurance Program (CHIP) offer free or low cost health coverage to children and families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage.

For information contact: Website: <http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml> or call 1-800-694-3084

For states other than Montana contact U.S. Department of Labor Website: [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call 1-866-444-3272

If you need help in filling out the information please contact the business office at Roosevelt Medical Center.

**Roosevelt Medical Center**  
 Financial Assistance Plan Application

PO Box 419 Culbertson, MT 59218 Phone: 406-787-6401

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE
HEALTH INSURANCE PLAN			SOCIAL SECURITY NUMBER	

Please list all household occupants

Name	Date of Birth	Name	Date of Birth
Self		DEPENDENT	
Spouse		DEPENDENT	
DEPENDENT		OTHER	
DEPENDENT		OTHER	

Please use the back of the form if you need more room for other occupants of your household.

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, pension, annuity, and veterans benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				
<b>Total Income</b>				

I certify that the family / household size and income information shown above is correct. Copies of tax returns, pay stubs and other information verifying income may be required before a discount is approved.

Name (print)  Date

Signature

Office Use Only

Patient Name  Discount

Date of Service

Approved by

Verification Checklist (attach Copies)	YES	NO
Identification/Address: Drivers' license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection		