**Roosevelt Medical Center**

PO Box 419
818 2nd Ave. East
Culbertson, MT 59218
406-787-6401
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.

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.**

| Family Size | Annual Income * Percentage that may be adjusted from your bill 100% | 75% | 50% | 25% | 0% |
|---|---|---|---|---|---|
| 1 | $14,580 | $21,870 | $29,159 | $29,160 | $29,161 |
| 2 | $19,720 | $29,580 | $39,439 | $39,440 | $39,441 |
| 3 | $24,860 | $37,290 | $49,719 | $49,720 | $49,721 |
| 4 | $30,000 | $45,000 | $59,999 | $60,000 | $60,001 |
| 5 | $35,140 | $52,710 | $70,279 | $70,280 | $70,281 |
| 6 | $40,280 | $60,420 | $80,559 | $80,560 | $80,561 |
| 7 | $45,420 | $68,130 | $90,839 | $90,840 | $90,841 |
| 8 | $50,560 | $75,840 | $101,119 | $101,120 | $101,121 |

* 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.

Payment Schedule

| If your Balance is | | | # of Monthly Payments |
|---|---|---|---|
| $1.00 | to | $100.00 | Balance in full |
| $100.01 | to | $600.00 | 6 |
| $600.01 | to | $1,200.00 | 12 |
| $1,200.01 | to | $2,400.00 | 15 |
| $2,400.01 | to | $3,000.00 | 18 |
| $3,000.01 | to | $4,000.00 | 21 |
| $4,000.01 | to | 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://apply.mt.gov/

For states other than Montana contact U.S. Department of Labor Website: 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

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

Financial Assistance Plan Application

| 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 | | | | |
| **Total Income** | | | | |

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 | | |