Have you heard about the Montana CHIP Program for children? Yes or No

Would you like more information about the program? Yes or No

I (we) certify that the information provided is true and accurate to the best of my (our) knowledge. I understand the information submitted concerning annual income, assets, and number of residents in my household is subject to verification by the Sidney Health Center. If any of the information I have given proves to be untrue, or I have intentionally omitted information , I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Please sign below:

_____

Signature

_____

Date

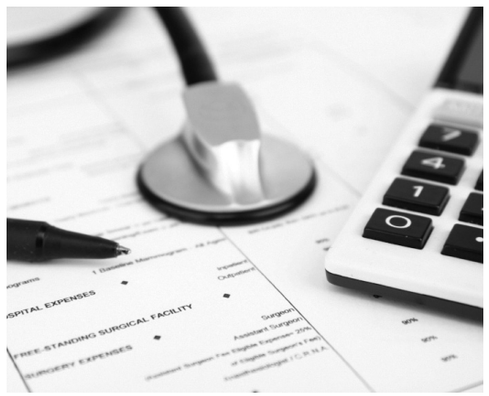
_____

Signature

_____

Date

Financial Assistance Application



Name: _____

Return by: _____

SIDNEY HEALTH CENTER

Exceptional Care for Life

216 14 Ave SW
Sidney, MT 59270
Phone: (406) 488-2100
www.sidneyhealth.org

Sidney Health Center Payment Options

At the Sidney Health Center , we understand that healthcare expenses may occur when you least expect them. To assist you through the process, Sidney Health Center offers a variety of payment options that are tailored to the individual lifestyles. Please call (406) 488-2114 with the plan you choose.

Interest Free Payment Plan

For those individuals who prefer to make payments, Sidney Health Center offers an interest-free payment plan for up to 12 months . Simply divide the balance by 12 to determine payment.

Loan Program

For the individuals who desire a lower monthly payment, Sidney Health Center offers a loan program. Interest is 15%, and your minimum payment is 4% of your balance. There is no application, simply call and let us know that you want to go on the program. We will send your account to the bank and you will receive a statement in the mail each month similar to a credit card bill.

Balloon Payment

Sidney Health Center also accepts lump sum payments after a series of lower monthly payments, (example: individuals may choose to pay small monthly payments for a period of time up to 12 months and then pay the balance due in one large payment when they receive a tax refund, farm payment, ect.)

Financial Assistance

Sidney Health Center offers reduced rates and financial assistance for individuals who need help paying their bill. The process requires completing a financial assistance application and is dependent on household income and family size. You maybe eligible for some assistance.

Financial Application

It is the policy of Sidney Health Center to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all eligible services received at this hospital, elective services and Medicaid spend down would be considered ineligible. This form must be completed at least every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
Total Income				

NOTE: Copies of most current tax return, 2 months worth of pay stubs, 3 months of bank statments, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (Print) _____

Signature _____ Date _____

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		