Livingston HealthCare
Billings Clinic Affiliate

REQUEST FOR FINANCIAL ASSISTANCE
Rural Health Clinic

Please complete the application below and return it with all documentation indicated so we may assist you with your financial responsibility to Livingston HealthCare Rural Health Clinic. List all family members you would like to have considered for financial assistance. Please note that financial assistance will be considered for any medically necessary services.

Financial assistance at Livingston HealthCare will be considered for residents of Montana, or established patients.

Livingston HealthCare cannot guarantee the outcome when applying for financial assistance, but will make every effort to help you resolve your accounts.

Please attach a copy of each of the following:

a) A completed, legible financial assistance application
b) A copy of the three (3) most recent pay stubs if employed or other evidence of income (and spouse's if applicable).
c) Proof of US citizenship or permanent residence status (driver license, utility bill)
d) An exemption notification from the Marketplace indicating that you were not eligible for assistance for insurance coverage plans offered by the Affordable Healthcare Act (if available)
e) Written verification from public assistance agencies, such as Medicaid, reflecting denials for eligibility (upon request) and as appropriate
f) Written verification of denial for unemployment or worker's compensation benefits (upon request) and as appropriate

Patient Name:_____ SSN:_____

Home Address:_____
Street *City* *State* *ZIP*

□ Own □ Rent □ Other: *(please explain)*_____

Phone Number:_____(home)_____(work)_____(alt.)

Place of Employment:_____

Spouse Name:_____ SSN:_____

Spouse Place of Employment:_____

Dependents:

Name	Age	Name	Age
1.		2.	
3.		4.	
5.		6.	

INCOME

Monthly Income (gross):

Patient $_____

Spouse $_____

Other Financial Support:

_____ $_____

_____ $_____

_____ $_____

Total Monthly Income: $_____

If you have any questions, please contact a patient financial services representative at (406)823-6414.

Signature: _____ **Date: _____**

Please return this application with all required documentation to:

Livingston HealthCare Financial Counselor
320 Alpenglow Lane
Livingston, MT 59047