

REQUEST FOR FINANCIAL ASSISTANCE LHC RURAL HEALTH CLINICS

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 cannot be considered for any type of elective medical services.

Financial assistance at Livingston HealthCare RHC's will be considered for all RHC patients visits in the RHC setting and will not be limited to residents of the state 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 patient's recent federal income tax return with proof of household income.

Patient Name: _____

Address: _____
Street City State ZIP

Phone Number: _____

Place of Employment: _____

Dependents:

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

Monthly Income (gross):

Family \$ _____

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