Northeast Montana Health Services, Inc.

Confidential Income and Insurance Statement
Appendix A

Name: ________________________________ Spouse: __________________________

Age: ____ Home Phone Number: ______________ Cell Phone Number: ____________

Present Address: ____

Social Security Number: ____-____-______

Dependents:

Name	Age	# Months in Home	Relationship to Patient

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Total Family Size: ______

Have you applied for Medicaid or Medicare benefits? Yes: ____ No: ____

Results: ____
**** If denied, you must submit the denial notice**

<u>Other</u> documents to accompany if applicable:

- **Last Income Tax return**
- **Last 3 employment pay stubs**
- **Denial by Indian Health Services**

PLEASE REFER TO ATTACHED POLICY AND PROCEDURE IF YOU HAVE QUESTIONS.

Date Application Received: ___________

Trinity Hospital
315 Knapp Street
Wolf Point, MT 59201
(406) 653-6500
Fax (406) 653-6589

Listerud Rural Health Clinic
301 Knapp Street
Wolf Point, MT 59201
(406) 653-2150
Fax (406) 653-6591

Poplar Community Hospital
P.O. Box 38
Poplar, Montana 59255
(406) 768-6100
Fax (406) 768-6160

Riverside Family Clinic
P.O. Box 629
Poplar, MT 59255
(406) 768-5171
Fax (406) 768-6161

Faith Lutheran Home
1000 6th Ave N
Wolf Point, MT 59201
(406) 653-1400
(406) 653-1433

FAMILY INCOME

List ALL sources of GROSS MONTHLY INCOME for the household

Employer: ____

________	**Unemployment Compensation**
________	**AFDC/TANF**
________	**Food Stamps**
________	**Child Support**
________	**Pension**
________	**Social Security**
________	**Land Lease**
________	**IIM Money**
________	**Disability Payment**
________	**Interest Income**
________	**Total Gross Monthly Income**

COMMENTS: ____

If any information you given is found to be false, you will be denied future discounts at Northeast Montana Health Services.

I acknowledge that the information given to Northeast Montana Health Services on this Financial Statement is true and correct. I authorize Northeast Montana Health Services to contact my employer (s) and or any county, state or federal programs to verify my income.

Applicant Signature: _________________________________ **Date:** _____________________

For Office Use Only

Total Monthly Family Income: ______________
Total Annual Family Income: ______________
Family Size: ______________
Fee Category % Discount: ______________
Amount Approved: ______________

Comments: ____
____
____

Approved By: ______________________________________ **Date:** ______________________