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

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: _____

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 count, 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: _____