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 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: _____