Dahl Memorial Healthcare Association
Financial Assistance Program

It is the policy of Dahl Memorial Healthcare Association (DMHA) as a non-profit charitable organization to provide health care to all persons in our community, including those with an inability to pay for those services. Our Financial Assistance Program is designed to provide assistance to responsible parties who desire to pay for their medical services but do not have the financial ability to do so. This program is intended to be the **last option for payment** after exhausting all other alternatives.

Financial assistance will be considered by DHMA for account balances no more than twelve (12) months past due from the date of this application. The determination to provide assistance will not apply to balances incurred after the application date.

To this end, responsible parties seeking financial assistance may apply for relief from DMHA through submittal of the following items for their household (all individuals living in the household, including those not legally related to you).

1. Completion of the attached Financial Statement

2. Proof of income as stated in the Financial Statement, as follows:

   a. Payroll check stubs or other monthly income sources for the last six (6) months for all persons in your household (whether legally related to you or not).
   b. A copy of your most recently completed calendar year IRS tax return with supporting schedules.

   c. Six (6) months of bank statements

3. Notice of ineligibility from other assistance programs such as Medicaid, SSI/SSDI, Crime Victims Assistance, etc.

4. Notice of ineligibility for unemployment or worker's compensation benefits, as appropriate.

5. A letter detailing your need for financial assistance.

The items listed above must be returned to Dahl Memorial Healthcare Association Business Office within twenty (20) business days. If circumstances prevent you from returning this application within that time frame, please contact the Business Office Manager. **An incomplete application will result in denial.** We will notify you of a final determination within thirty (30) calendar days of our receipt of your completed application.

DMHA will provide personal assistance in understanding our Financial Assistance Program and will assist any responsible party in completing this application, if requested.

All information submitted as a part of this application will be kept confidential.

DEFINITIONS

1. Responsible Party -- the patient or any individual legally obligated to pay for the patient's medical care debts, excluding third party payers. A responsible party is accountable for all of a patient's medical care debts, regardless of how much will ultimately be covered by a third-party payer.

2. Third-Party Payer -- Any financial agent of entity, such as an insurance carrier, HMO, employee benefit plan, or government payer, with a legally enforceable obligation to pay for services billed to a patient by DMHA. (Responsible parties, as defined herein, are not considered third-party payers.)

3. Household --A household consists of all persons who occupy the same housing unit as the applicant whether they are legally related to each other or not, and would be recognized as being in the same household under the Federal income poverty guidelines. DMHA will consider household assets and income to make a determination of financial assistance under this program.

4. Income --Income is the total annual cash receipts from all sources which includes, but is no limited to, wages and salaries before deductions, net receipts from non-farm self employment income, net receipts from farm self-employment, social security payments, railroad retirement, unemployment compensations, workers compensation benefits, veterans' payments, public assistance payments, Supplemental Security Income, Social Security Disability Income, alimony, child support, military allotments, private pensions, government pensions, annuity payments, college or university scholarships, grants, fellowships, dividends, interest, net rental income, net royalties, inheritance, periodic receipts from estates or trusts, survivors dependents benefits, contract payments, net gambling of lottery winnings and settlement income.

5. Assets-- Property of all kinds, real and personal, tangible and intangible that is legally applicable or subject to the payments of the responsible party's debts, including, but not limited to: cash on hand, checking and savings accounts, vehicles, homes and rental properties, mineral rights and livestock, stocks, bonds, mutual funds, and any other investments, and assets related to earning a livelihood.

DAHL MEMORIAL HEALTHCARE ASSN.
PO BOX 46
EKALAKA, MT 59324
406-775-8738
FAX 406-775-6706

Application for Financial Assistance

Applicant Name: _____

Application Date: _____

As the responsible party for, _____ I would like to submit this application for eligibility review under the Dahl Memorial Healthcare Association (DMHA) Financial Assistance Program. I hereby authorize DMHA to contact entities itemized on my "Individual Financial Statement" to verify my employment, income, assets, liabilities, etc.

I further hereby affirm that the information contained in this application is true, complete, and correct. I understand that if any submitted documentation or information is deemed to be untrue or falsified, my eligibility under this program will be denied without appeal.

Signature: _____

FINANCIAL STATEMENT

1. Head of Household _____ **Spouse** _____

Address: _____
Box / Street Address City State Zip

Telephone Number: **(____)**_____ Cell **(____)**_____

2. Occupation (self) _____ **Social Security No.**_____

Employer_____
Name Address Phone

Occupation (spouse) _____ Social Security No._____

Employer _____
Name Address Phone

3. Other Members residing in the Household (Please list first and last names):

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Income: All Income for This Household	**Last 6 Months**	**Last 12 Months**
Wages (Gross Income before Taxes)	$_____	$_____
Farm or Self-Employment Income	_____	_____
Social Security or Supplemental Security (SSI)	_____	_____
Public Assistance (Food Stamps, AFDC, etc.)	_____	_____
Unemployment Compensation	_____	_____
Worker's Compensation	_____	_____
Alimony or Child Support	_____	_____
Income Tax Refunds	_____	_____
Military Family Allotments	_____	_____
Pension / Retirement Payments	_____	_____
Rent / Interest / Dividends	_____	_____
Income from Sale of Property	_____	_____
Inheritance / Royalties	_____	_____
Settlement Income (Worker's Comp, Lawsuit, etc.)	_____	_____
Other _____	_____	_____
TOTALS:	$_____	$_____

5. Household Expenses:	**Monthly**	**Annually**
Rent or Mortgage Payment	$_____	$_____
Food & Groceries	_____	_____
Electricity / Gas / Propane, etc.	_____	_____
Phone / Cell Phone	_____	_____
Internet	_____	_____
Water / Sewer, etc.	_____	_____
Television (Cable, Satellite)	_____	_____
Vehicle Repairs, Gasoline, etc.	_____	_____
Insurance (Health, Home, Auto, Life, etc.)	_____	_____
Child Care	_____	_____
Child Support	_____	_____
Healthcare Services & Pharmacy	_____	_____
Alimony	_____	_____
Property Tax	_____	_____
Income Tax (Federal, State, FICA, Medicare)	_____	_____
TOTALS:	$_____	$_____

6. ASSETS (I OWN)	**Account #**	**Institution**	**Value / Balance**
Cash on Hand	_____	_____	_____
Savings	_____	_____	_____
Checking	_____	_____	_____
Stock/Mutual Funds	_____	_____	_____
Life Insurance Cash Value	_____	_____	_____
Bonds/CDs/IRAs	_____	_____	_____

Mineral Rights (Description of):

$_____

Livestock (Description of):

$_____

Owned Home (Primary Residence)

Purchase Price $_____
Improvements $ _____
Estimated Value $_____

Other Property Owned:

Description:_____
_____
_____

Estimated Value $_____

Automobiles
Year / Make / Model / Value

_____
_____
_____

Other Vehicles (RV, Boat, Motorcycle, etc.)
Year / Make / Model / Value

_____
_____
_____

TOTAL ASSETS: $_____

9. LIABILITIES (I OWE)	**Account #**	**Mo. Payment**	**Balance Owed**
Bank & Credit Union Loans			
_____	_____	$_____	$_____
_____	_____	$_____	$_____
Mortgages			
_____	_____	$_____	$_____
_____	_____	$_____	$_____
Automobile / Other Vehicle Loans			
_____	_____	$_____	$_____
_____	_____	$_____	$_____
Credit Card Accounts			
_____	_____	$_____	$_____
_____	_____	$_____	$_____
Other Liabilities			
_____	_____	$_____	$_____
_____	_____	$_____	$_____
Medical Expenses (Please List)			
_____	_____	$_____	$_____
_____	_____	$_____	$_____
TOTAL LIABILITIES:		$_____	$_____