



REQUEST FOR FINANCIAL ASSISTANCE

Please complete the application below and return it with all documentation indicated so we may assist you with your financial responsibility to Livingston HealthCare. 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 will be considered for residents of Park, Meagher or Sweet Grass Counties.

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:

1. Most current tax return—for each adult household member
2. Determination letter from Medicaid and/or Social Security Disability
3. Medical expenses (other than Livingston HealthCare)
4. Last three (3) pay stubs
5. Last three (3) months bank statements

Patient Name: _____ SSN: _____

Home Address: _____
Street City State ZIP

Own Rent Other: *(please explain)* _____

Phone Number: _____ (home) _____ (work) _____ (alt.)

Place of Employment: _____

Spouse Name: _____ SSN: _____

Spouse Place of Employment: _____

Dependents:

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

ASSETS

	Year	Make	Model	Purchase Price	Balance Owed	Estimated Value
Vehicle #1						
Vehicle #2						
Vehicle #3						
Trailer/Camper						
Recreational Veh.						
Other:						
Other:						
Other:						

Account Name	Current Balance	Account Name	Current Balance
Checking		Stocks	
Savings		Bonds	
		CDs	

Retirement Funds:

IRA: _____

401K: _____

403B: _____

Other: _____

Total Assets: \$ _____

(Please include estimated value of vehicles.)

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

504 South 13th Street

Livingston, MT 59047