DANIELS MEMORIAL HEALTHCARE CENTER
PO BOX 400
SCOBEY, MT 59263
406-487-2296

OPERATED BY
DANIELS MEMORIAL HOSPITAL
PO BOX 400
SCOBEY, MONTANA 59263

Financial Assistance Worksheet

All other sources of payment must be exhausted before this office will consider any finacial assistance. You are expected to apply for any public assistance, supplemental security income and/or medicare which may be available to you.

PATIENT NAME:_____

ACCOUNT #:_____

HOUSEHOLD INFORMATION: (Other family members living in the same residence)

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE/MEDICAL COVERAGE? YES_____ NO_____ TYPE_____

HOUSEHOLD MONTHLY INCOME:

Wages	_____
Social Security Benefits	_____
Unemployment Benefits	_____
Workers Comp. Benefits	_____
Pension	_____
Child Support	_____
Alimony	_____
Other (Please list)	_____
	_____

OFFICE USE ONLY:
Account Balance: _____
Payments Made: _____
Application taken by:
_____

Approved: _____
Not Approved: _____

Name:_____

This is to certify that I am unable to meet my financial obligations to the_____ for medical services rendered. Completion of this form is my request for assistance to help satisfy my obligations. The completion of this form does not gaurantee assistance will be provided. I further certify that the information given on this form is true and correct to the best of my knowledge. I agree to provide of documents supporting the above information as requested by this office.

Patient/Guarantor:_____ Date:_____

Please attach a copy of your most recent pay stub and tax return