Financial Assistance Form

Community Medical Center is able to consider reductions on your bill based on individual financial need. In order for us to consider your request, this form must be completed and returned within 14 days. Your signature authorizes Community Medical Center to verify information provided in this financial statement, to obtain a credit report and/or other financial information. **Approval requires a copy of your most recent tax return.**

Signature: ____________________________________ Date:________________

Spouse Signature: ______________________________ Date: ________________

Patient Account:

Account Number:	Balance: $

Name:	SSN:	Date of Birth:
Spouse:	SSN:	Date of Birth:
Address:	City/State:	Zip Code:
Daytime Telephone:	Message Phone:	
Employer:	Position:	Date of Employment:
Does your employer offer insurance?	Y/N	
Spouse Employer	Position:	Date of Employment:
Number of Dependents:	Name and Age of Dependents:	Total Number in Household:

Monthly Income:

	Patient	***Other***
Employment (Gross Wages)		
Unemployment		
Bonuses/Tips		
Public Assistance		
Social Security/Pensions		
Worker's Compensation		
Alimony/Child Support		
Other Sources		
Total Monthly Income		

Assets:

Cash on Hand	$
Checking Account Balance	$
Savings Account Balance	$
Stocks/Bonds/IRA/401K	$
Cash Value of Life Insurance	$
Auto 1	
Year/Make	
Model	
Value	$
Loan Balance	$
Auto 2	
Year/Make	
Model	
Value	$
Loan Balance	$
Current Home Value	$
Purchase Date	
Purchase Price	$
Mortgage Loan Balance	$
Other Property (Describe)	$
Recreational Merchandise (Describe)	$
Other Assets (Describe)	$
Total Assets	$

Monthly Expenses

Rent or House Payment	$
Utilities	$
Phone	$
Cable	$
Groceries	$
Prescriptions	$
Clothing	$
Childcare	$
Car Insurance	$
Monthly Payment (Auto 1)	$
Monthly Payment (Auto 2)	$
Health Insurance	$
Life Insurance	$
Entertainment	$
Other	$
Credit Cards: 1. 2. 3. 4. 5.	 $ $ $ $ $
Medical Bills 1. 2. 3. 4. 5. 6.	$ $ $ $ $ $ $
Total Monthly Expenses	$

Signature: ____

Additional Information:

If you expect a change in income, health, other circumstances or cannot provide the requested information, please explain. Also, if you indicate that you have no income, please explain how you meet your day to day expenses.

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Please return to:

Community Medical Center
Attn: Patient Financial Services
2827 Fort Missoula Rd
Missoula, MT 59804

Contact: ______________________________________

Signature ____