



600 MT Highway 91 South · Dillon, MT 59725 · (406) 683-3000
www.barrethospital.org

Financial Assistance Screening Form

Patient Name (Please Print) _____ DOB: _____
 Account Number(s) _____ Est. Balance: _____
 Patient Age: _____ Family Size: _____ Gross Family Income: _____

Category (circle one) Financial Assistance Application Given – Set Up Payment Plan

Instructions: BHHC staff will work with the patient to answer the questions below and then take the actions indicated in the Additional Actions column for all questions answered with a YES.			
Additional Info.	Mark Accordingly	Category	Additional Action
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are services elective? (refer to the FA acuity indicators)	Yes = Doesn't qualify No = Refer to PFA
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient is deceased with no known estate or other resources.	Refer to PFA
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient is homeless and/or has received care from a homeless clinic or shelter.	Refer to PFA and/or Social Services
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient/Family has received care from and/or has participated in Women's, Infant's and Children's (WIC), MT Cancer Control/Screening, or other such program. Program Name: _____	Check attached FA Guidelines
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient qualifies for state or local assistance programs. (i.e. Medicaid, food stamps, etc.) Program Name: _____	Check attached FA Guidelines
	<input type="checkbox"/> Yes <input type="checkbox"/> No	The patient lives in an affordable or subsidized housing development	Check attached FA Guidelines
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has been granted financial assistance through another hospital / facility in the last 8 months.	Refer to PFA
	<input type="checkbox"/> Yes <input type="checkbox"/> No	The patient / guardian indicates that they do not have the money to pay their bill (s)	Check attached FA Guidelines
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's medical bills equal or exceed 3x their gross income	Refer to PFA
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient would like to be considered for FA based on a special consideration (specify): _____	Refer to PFA

I certify that the above information was given in good faith and, to the best of my knowledge, is true and correct.

Patient / Guardian: _____ Date: _____

Personal Finance Advocate: _____ Date: _____

	If the patient falls into this column based on family size and gross income provide a financial assistance application	If the patient falls into this column, he/she does not qualify for assistance, set up a payment plan
1	\$0 - \$25,760.00	\$25,760.01 or more
2	\$0 - \$34,840.00	\$34,840.01 or more
3	\$0 - \$43,920.00	\$43,920.01 or more
4	\$0 - \$53,000.00	\$53,000.01 or more
5	\$0 - \$62,080.00	\$62,080.01 or more
6	\$0 - \$71,160.00	\$71,160.01 or more
7	\$0 - \$80,240.00	\$80,240.01 or more
8	\$0 - \$89,320.00	\$89,320.01 or more

If patient falls into this column, he/she does not qualify for assistance, set up payment plan

Barrett Hospital & Healthcare financial assistance program is a onetime assistance and is a payer of last resort. If patient is eligible for Medicaid, HMK, Montana HELP, or any other form of aid, all efforts must be exhausted with that entity before continuing the application process.

The financial assistance application is provided once the screening has taken place and the patient/family falls within income guidelines based on initial information provided. **THIS IS NOT AN APPROVAL FOR FINANCIAL ASSISTANCE.** Once the application is completed and submitted back to the personal finance advocate (PFA) with supporting documentation attached, the finance advocate will then present the information to committee on the third Tuesday of every month. The approval is ultimately up to the committee and will either be granted at 100% or assistance will be denied. If the application and **ALL** documentation are **NOT** returned by the deadline, the application is not eligible for financial assistance consideration.

Patients that do not appear to qualify for any program post screening will be recommended for payment plan options. Payment in full is required in accordance with the payment policy. Any payment plan that extends those dates will be handled courtesy of our extended business office.

Patient/Guardian: _____ Date: _____