BARRETT
HOSPITAL & HEALTHCARE

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

Sample Form: Do not print

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
	☐ Yes ☐ No	Are services elective? (refer to the FA acuity indicators)	Yes = Doesn't qualify No = Refer to PFA
	☐ Yes ☐ No	Patient is deceased with no known estate or other resources.	Refer to PFA
	☐ Yes ☐ No	Patient is homeless and/or has received care from a homeless clinic or shelter.	Refer to PFA and/or Social Services
	☐ Yes ☐ 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
	☐ Yes ☐ No	Patient qualifies for state or local assistance programs. (i.e. Medicaid, food stamps, etc.) Program Name: _____________________________________	Check attached FA Guidelines
	☐ Yes ☐ No	The patient lives in an affordable or subsidized housing development	Check attached FA Guidelines
	☐ Yes ☐ No	Patient has been granted financial assistance through another hospital / facility in the last 8 months.	Refer to PFA
	☐ Yes ☐ No	The patient / guardian indicates that they do not have the money to pay their bill (s)	Check attached FA Guidelines
	☐ Yes ☐ No	Patient's medical bills equal or exceed 3x their gross income	Refer to PFA
	☐ Yes ☐ 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: ________________

Sample Form: Do not print

	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 - $30,120.00	$30,120.01 or more
2	$0 - $40,880.00	$40,880.01 or more
3	$0 - $51,640.00	$51,640.01 or more
4	$0 - $62,400.00	$62,400.01 or more
5	$0 - $73,160.00	$73,160.01 or more
6	$0 - $83,920.00	$83,920.01 or more
7	$0 - $94,680.00	$94,680.01 or more
8	$0 - $105,440.00	$105,440.01 or more

For families/households with more than 8 persons, add $5,380 for each additional person.

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.

Sample Form: Do not print

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: ____________________