COMMUNITY HOSPITAL OF ANACONDA
401 West Pennsylvania • Anaconda, Montana 59711 • Phone: 406/563-8500 • Fax: 406/563-8565

To Our Patients:

The Community Hospital of Anaconda offers financial assistance to our patients that are unable to pay their account balance within the required guidelines. The program is designed to lower your payments and possibly reduce your balance by evaluating your financial situation.

To apply, simply fill out the two-page application and collect the required documentation listed on the first page. Once the paperwork is received in our office, your application will be reviewed and submitted to Administration for approval. Once a decision is reached, you will be contacted with the results and what, *if* any, further actions need to be taken.

We strongly encourage you to apply for the program. You may greatly benefit from the short amount of time it takes to complete the application and compile the required documents! It's just one more way the Community Hospital can provide "care for a lifetime."

If you need any help completing the application or have questions, please contact us at your earliest convenience 406-563-8536. We look forward to assisting you in any way we can!

Patient Access Department
Community Hospital of Anaconda

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Financial Assistance Application

To be considered for financial assistance, **you MUST provide the following:**

1. The completed and signed application.
2. Copy of your most current Federal Tax Return.
3. Verification of income for the past 2 months to validate household income.
4. Supporting documentation of all forms of income (Social Security, unemployment benefits, public assistance, child support, etc.).

Please mail or drop off application and all supporting documentation to:

Community Hospital of Anaconda Attn: Patient Access
401 W. Pennsylvania
Anaconda, MT 59711

Community Hospital of Anaconda is able to consider reduced patient payments based on individual financial need. In order for us to consider your request, this packet must be completed and returned within thirty (30) days. Your signature authorizes Community Hospital of Anaconda to verify information provided in this financial statement. Financial assistance is available only after all other forms of reimbursement (health insurance, Medicaid, or third-party insurance) have been exhausted.

Financial Assistance Application

Name: _____ DOB: _____

Address: _____ City/State: _____ Zip: _____

Phone Number: _____ Message Phone: _____

Family Size			
Total number of persons living in household: _____			
	Name	Relationship	DOB
Guarantor/Patient			
Spouse			
Child			
Child			
Child			
Child			
Child			
Other Family Member			
Other Family Member			

Income (Monthly)				
	Person 1	Person 2	Person 3	Grand Total
Gross Wages/Salary	$	$	$	$
*Employer Name				
*Position				
*Start Date				
Unemployment	$	$	$	$
Public Assistance	$	$	$	$
Social Security	$	$	$	$
Retirement/Pension	$	$	$	$
VA Benefits	$	$	$	$
Workers Comp	$	$	$	$
Child Support	$	$	$	$
Other	$	$	$	$
Other	$	$	$	$
Combined Total	$	$	$	$

I am requesting monthly payments in the amount of $ _____.

Please use this space to explain if you cannot provide requested documents or if you expect changes in income or other circumstances. Also, if you have no income, explain how you meet day-to-day expenses. Lastly, you can take this opportunity to explain your current situation. (Please attach a separate sheet if you need additional space.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____