KALISPELL REGIONAL HEALTHCARE

Date: _____

Completion of this Financial Assistance Application will allow us to determine if Kalispell Regional Healthcare is able to consider reduced payments based on financial need.

Patient Name	***SSN***	***Date of Birth***
Address	***City/State***	***Zip Code***
Home Telephone	***Work Telephone***	***Cell***
Employer	***Position***	***Date of Employment***
Spouse/Significant Other Name	***SSN***	***Date of Birth***
Address (if different from Patient)	***City/State***	***Zip Code***
Spouse/Significant Other's Employer	***Position***	***Date of Employment***
Name of Dependents(s) and DOB:		***Total Household Size***
E-Mail		
Insurance		

Monthly Income:	***Yourself***	***Spouse/significant other***
Employment/Gross Wages		
Social Security/Pension Income		
Public Assistance		
Unemployment Benefits		
Alimony/Child Support		
Worker's Compensation		
Any other sources of Income (describe)		
Total Monthly Income		

KALISPELL REGIONAL HEALTHCARE

Assets:		*Monthly Expenses:*	
Cash/Checking Balance	$	***Rent or House Payment***	$
Savings Account Balance	$	***Utilities***	$
Stocks/Bonds/IRA/401K	$	***Telephone***	$
		Cable	$
Auto 1		***Groceries***	$
Year/Make		***Prescriptions***	$
Model		***Childcare***	$
Value	$	***Child Support***	$
Loan Balance		***Monthly Payment (Auto 1)***	$
Auto 2		***Monthly Payment (Auto 2)***	$
Year/Make		***Vehicle Insurance***	$
Model		***Vehicle Maintenance/Gasoline***	$
Value	$	***Health Insurance***	$
Loan Balance	$	***Life Insurance***	$
		Other Loan payments	$
Current Home Value	$	***Payments on Credit Cards***	$
Purchase Date			$
Purchase Price	$		$
Mortgage Loan Balance	$	***Payments on Medical Bills***	$
Other Property (Describe)	$		$
Recreational Merchandise	$		$
Other Assets (Describe)	$		$
Total Assets	$	***Total Monthly Expenses***	$

KALISPELL REGIONAL HEALTHCARE

Additional Information:

If you are not able to provide the information on this application please explain.

If you have no income, please explain how you meet your daily expenses.

Please provide any additional information about any other circumstances that you think will better help us to understand your situation.

Clinics: Please list the name(s) of clinics you would like us to consider for financial assistance.

Signature: _____ ***Date:*** _____

Spouse Signature: _____ ***Date:*** _____

Your signature authorizes Kalispell Regional Healthcare to verify information provided in this financial statement by obtaining a credit report and/or other financial information.

If you have any questions or are unable to provide complete information, please contact us at 406-752-1767.

Return application:
Kalispell Regional Medical Center
Attn: Financial Advising Dept.
310 Sunnyview Lane
Kalispell, MT 59901
Financial Advisors 406-752-1767

Telephone Numbers:
Customer Service & Statement Questions
Please contact patient accounts at 406-756-4408
Toll Free in the U.S. 844-349-7900
In Canada: 844-349-7900