P.O. Box 1228
301 W. 7th Avenue
Big Timber, MT 59011
406-932-4603
Fax 406-932-5468
www.pmcmt.org

Request for Financial Assistance

You or your family member has requested a reduction on your bills related to care provided by Pioneer Medical Center. We would like to assist you with your request by conducting a reasonable financial assessment based on your current financial status. Please note that financial assistance cannot be considered for any type of elective medical services. We cannot guarantee that your financial status will justify a reduction on balances owed, but we will make every effort to work with you in trying to resolve your accounts.

In order to expedite your request, we will need you to provide us with all information no later than 20 days from receipt of this letter. If for any reason this cannot be completed within this timeframe, please contact Mary Parker at (406)932-4603 to communicate your concerns.

Please complete the form that follows and return it along with the documentation indicated below:

1. Copy of last year's tax returns. (If married and filing separately, please provide both returns).
2. Copy of the determination letter from Medical Assistance and/or Social Security.
3. Proof of monthly living expenses as recorded on this form.
4. Copies of other medical expenses.
5. Provide copies of your last three (3) pay stubs.
6. Copy of any/all insurance cards.
7. Copy of last three months bank statements.

Patient Name:_____S.S.#_____

Spouse Name (if any):_____S.S.#_____

Home Address (Street, City, State, Zip):_____

Contact Phone Number:_____ Alternate Contact Number_____

Number of Dependents:_____ Names & Ages:_____

Living Arrangements: ___ Own, ___ Rent, ____ Other (explain below)

Assets (autos, campers, snow machines, boats, stocks, bonds, IRA's, 401K's) _____

_____

Do you receive financial support from a family member (or other source)?_____

If Yes, explain:_____

Monthly Expenses:

Rent/Mortgage: $_____

Food: $_____

Utilities: $_____

Phone: $_____

Auto/Transportation: $_____

Other Expenses for Dependents: $_____

Total Monthly Expenses: $_____

Monthly Income:

Patient (Self): $_____

Spouse: $_____

Other Income: $_____

Total Income: $_____

Savings: Y / N Amount: $_____

Checking: Y /N Amount: $_____