NORTHERN MONTANA HEALTH CARE
30 13TH STREET P.O. BOX 1231 HAVRE, MT 59501 (406) 262-1264

FINANCIAL ASSISTANCE APPLICATION

Guarantor:______________________________ Spouse:______________________________

SS#:____________________ D.O.B:__________ SS#:____________________ D.O.B:__________

Street Address:__________________________ Street Address:__________________________

Mailing Address:_________________________ Mailing Address:_________________________

City/State/Zip:__________________________ City/State/Zip:__________________________

Home/Cell Phone:________________________ Work Phone:______________________________

Date of Marriage:________________________ Date of Divorce:__________________________

Please list the name, relationship, and age of all people living in your home:

Name:______________________ Relationship:______ Age:__ SS#:__________________

Name:______________________ Relationship:______ Age:__ SS#:__________________

Name:______________________ Relationship:______ Age:__ SS#:__________________

Name:______________________ Relationship:______ Age:__ SS#:__________________

EMPLOYMENT HISTORY – *Please include any seasonal employment*
(Attach a copy of previous 3 months pay stubs and your most current Federal Income Tax Return for all people living in your home.

Present Employer

Name:_________________________________

Phone#:_______________________________

Position:_____________________________

How long Employed:____________ FT ☐ PT ☐

Wage $_____/hour Pay Dates:________

Gross Monthly Income: $________________

Spouse/Other - Employer

Name:_________________________________

Phone#:_______________________________

Position:_____________________________

How long Employed:____________ FT ☐ PT ☐

Wage $_____/hour Pay Dates:________

Gross Monthly Income: $________________

Second Job

Name:_________________________________

Phone#:_______________________________

Position:_____________________________

How long Employed:____________ FT ☐ PT ☐

Wage $______/hour Pay Dates:_________

Gross Monthly Income: $________________

Spouse/Other Second Job

Name:_________________________________

Phone#:_______________________________

Position:_____________________________

How long Employed:____________ FT ☐ PT ☐

Wage $______/hour Pay Dates:_________

Gross Monthly Income: $________________

Are you a college student? Yes ☐ or No ☐

If yes, are you claimed on parent (s) income tax?____________________

ADDITIONAL INCOME

Self		**Spouse/Other**	
Social Security/Pension	$__________	Social Security/Pension	$__________
Child Support/Alimony	$__________	Child Support/Alimony	$__________
Student Financial Aid	$__________	Student Financial Aid	$__________
Bonuses/Gifts	$__________	Bonuses/Gifts	$__________
Interest/Dividends	$__________	Interest/Dividends	$__________
Disability	$__________	Disability	$__________
Unemployment	$__________	Unemployment	$__________
Worker's Compensation	$__________	Worker's Compensation	$__________
VA	$__________	VA	$__________
Military	$__________	Military	$__________
Misc.	$__________	Misc.	$__________
Total	**$**__________	**Total**	**$**__________
Total Monthly Gross & Additional Income	**$**__________	**Total Monthly Gross & Additional Income**	**$**__________

- ***Bank statements may be requested when income exceeds 200% FPG***

If no proof of income or tax return enclosed, your financial application may be denied.

Proof of income includes: Social Security/Disability Benefits, Worker's Compensation, Child Support, Unemployment, Wage Earning Statement, and Pay Stubs.

I acknowledge that the information given to Northern Montana Hospital on this Financial Statement is true and correct. I authorize Northern Montana Hospital to verify all of the information listed above.

If you have any questions, please contact:______________________________

Applicant's Signature:__________________________ **Date:**____________

Spouse's Signature:__________________________ **Date:**____________