NORTHERN MONTANA HEALTH CARE
30 13TH STREET P.O. BOX 1231 HAVRE, MT 59501 (406) 262-1708

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:_____

Date of Marriage:_____ Date of Divorce:_____

Please provide the following information so we can contact you regarding this document:
Home Phone:_____ Work Phone:_____ Cell Phone:_____

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.

Applicant's Signature:_____ **Date:**_____

Spouse's Signature:_____ **Date:**_____