McCone County Health Center
P.O. Box 48
605 Sullivan Ave.
Circle, MT. 59215
406-485-3381

APPLICATION FOR HILL-BURTON ASSISTANCE

Name: _____
Last First MI

Address: _____
Street or PO Box City State Zip Code

SS# _____ Home Phone: _____

Employer: _____
Address City State Zip Code

Patient's Gross Income: _____(Last 12 months or last 3 months X 4)

Other Family Income: _____

Total Family Income: _____ Family Size:_____

Type of Service Rendered/Requested: _____

Date(s) of Service: _____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicare, Insurance, Medicaid, etc.), which may be available for payment of my McCone County Health Center charges (*McCone Clinic charges and physical therapy services are not eligible for charity care*), and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the Critical Access Hospital (CAH) the amount recovered for charges.

I understand that this application is made so that McCone County Health Center can judge my eligibility for uncompensated services under the Hill-Burton Act, based on the established criteria on file at the CAH. If any information I have given proves to be untrue, I understand that the CAH may re-evaluate my financial status and take whatever action becomes appropriate. I understand that this policy does not apply to Medicare Co-Payments or Deductibles.

**** Please include a copy of your income for the last 12 months (check stubs, printout from your employer).**

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

POVERTY GUIDELINES (rev. 01/25/16)

Family Size	Category A Poverty guide	Category B Hospital
1	$11,880	$23,760
2	$16,020	$32,040
3	$20,160	$40,320
4	$24,300	$48,600
5	$28,440	$56,880
6	$32,580	$65,160
7	$36,730	$73,460
8	$40,890	$122,670
Over 8 persons	Add $4,160 per person	Add $8,320 per person

ELIGIBILITY DETERMINATION (For Office Use Only)

Date Application Received: _____

Income Verified: Yes_____ No _____

Type of Verification: _____

_____ The applicant is approved / conditionally approved (circle one) for care at no charge under Category A / Category B (circle one) of the Poverty Income Guidelines.

Amount provided as uncompensated service is: _____

Condition(s) if applicable: _____

_____

_____ The applicant's request for free or reduced charge services has been denied for the following reason:

_____

_____

Date of Conditional Determination: _____ Date of Final Determination: _____

Date Applicant Notified: _____

Signature: _____
(Individual Authorized to Make the Determination)