Ruby Valley Medical Center

Financial Assistance Program

Plain Language Summary

The Ruby Valley Medical Center offers financial assistance for emergency treatment and medically necessary healthcare services to all who qualify. Our hospital's Business Office can assist patients in exploring all options for financial assistance.

We encourage all interested patients to apply for assistance. Determination is based on income and household size guidelines, relative to the Federal Poverty Level. This assures our ability to designate these resources to patients who will benefit most and address the greater needs within the community. Patients are expected to cooperate with the Ruby Valley Medical Center's procedures for obtaining financial assistance and to contribute to the cost of care based on the individual or family's ability to pay.

Obtaining & Submitting an Appication

Patients may obtain copies of the financial assistance policy and financial assistance application on our website (www.RVMC.org/patient-resources), via the mail by calling (406) 842-5453, or in person at the registration desk at 321 Madison Street, Sheridan, Montana 59749 or 104 S. Madison Street, Twin Bridges, Montana, 59754. There is a separate application for the Ruby Valley Rural Health Clinic's Sliding Scale Program. Both applications can be found on our website or upon request at the registration desks. Currently, the application is only available in English.

The application and copies of the requested items must be returned to the Business Office within 14 days of receipt. The documents can be submitted personally to 321 Madison Street, Sheridan or by mail to Ruby Valley Medical Center, Business Office, P.O. Box 336, Sheridan, MT 59749.

Eligibility

If you feel that you may need assistance to fulfill your financial obligation to the medical center, please review the Financial Assistance Policy and complete the Financial Assistance application. If your household earns less than 200% of the published federal poverty level, you are eligible to apply for assistance. The Business Office staff can assist you with the completion of the application.

Verification of Income

For income verification purposes, the following documentation will be needed -

1. A copy of your filed income tax return and W2s for the past year.
2. Current year-to-date pay records or written verification of wages from your employer.
3. Social Security income (also include children's).
4. Child support for the previous year and current year-to-date payments.
5. Bank statements for the last 3 months (savings, checking, brokerage, etc.)
6. If applicable, unemployment or workers compensation benefits.
7. If applicable, public assistance eligibility or denial.

Qualification

Applicants will be notified in writing or by phone if they are eligible and what percentage of their account will be credited. Individuals eligible for financial assistance will not be charged more than the amounts generally billed for emergency or other medically-necessary care. Applicants are eligible to reapply at any time for financial assistance if their financial situation changes.

Failure to satisfy the requirements can result in your application being void. If you have any questions regarding the Financial Assistance Program, please contact the Business Office at (406) 842-5453.

321 Madison Street
P.O. Box 336
Sheridan, MT 59749
(406) 842-5453

The Ruby Valley Medical Center is an equal opportunity provider and employer
www.RVMC.org

Twin Bridges Clinic
104 S. Madison Street
Twin Bridges, MT 59754
(406) 684-5546

THE RUBY VALLEY MEDICAL CENTER

APPLICATION FOR THE RUBY VALLEY MEDICAL CENTER ASSISTANCE PROGRAM

Date of Application_____

Applicant Name_____

SS#_____DOB_____Phone_____

Address_____

Address_____

City_____State_____Zip_____

Members of Household

Name_____SS#_____DOB_____

Name_____SS#_____DOB_____

Name_____SS#_____DOB_____

Name_____SS#_____DOB_____

Name_____SS#_____DOB_____

Name_____SS#_____DOB_____

	Account #	**Amount**
Patient Account(s) #/Amount	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

THE RUBY VALLEY MEDICAL CENTER

INCOME (Include all household members)

	Total for last 3 Months
Gross Wages	_____
Social Security Benefits	_____
Pension Income	_____
Public Assistance	_____
Dividend & Interest	_____
Rental Income	_____
Farm or Self Employment Income	_____
Unemploymsent Compensation	_____
Worker's Compensation	_____
Strike Benefits	_____
VA Benefits	_____
Military Family Allotments	_____
Alimony	_____
Child Support	_____
Other Income	_____
TOTAL INCOME (before taxes)	_____

Please provide copies of your recent 1040 and W-2 and/or three months of current pay stubs, and/or medical assistance notice of denial or eligibility. Additional information on assets may be requested. If no proof of income or tax return enclosed, your financial application will be denied.

EMPLOYER INFORMATION

Head of Household Employer Name_____Ph_____

Employer Address_____

Additional Employer Name_____ Ph_____

Employer Address_____

I certify that the information given to Ruby Valley Medical Center is true and correct to the best of my knowledge and further agree that falsification herein will disqualify me or my dependent(s) for charitable services. I understand the information submitted is subject to verification.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature Date

DO NOT COMPLETE – FOR OFFICE USE ONLY

Ruby Valley Medical Center Amount $_____

Total Annual Gross Income:_____ Family Size:_____

Guidelines:_____ Amount Approved $_____ % Approved_____

Comments:_____

_____

_____

_____

_____

_____

Approved by:_____ Date:_____