Application for Financial Assistance

B·I·L·L·I·N·G·S Dermatology & Aesthetics

Please fill out this financial statement by answering the following questions. When completed, please mail to:

Billings Dermatology, Billing Office
2294 Grant Road, Billings, MT 59102

Name: _____

Address: _____

Phone number: _____

Date of Birth: _____

1. Do you have insurance that will cover any or all of the charges for services with our office?
   Yes ___ No ___
2. In the last 6 months, did you receive food stamps and/or energy assistance?
   Yes ___ No ___
3. Are you now unemployed?
   Yes ___ No ___
   Please check all reason that apply:
   Health Problems ___ Unable to find work ___ Student ___
   Injury ___ Laid Off ___ Not seeking employment ___ Retired ___
4. Please list name and date of birth of additional household members:
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____
   6. _____
   7. _____
   8. _____
5. What is your family's "GROSS" (before taxes) annual income?
   _____

Please attach the following information:

- ❑Picture Identification: Driver's License or government issued ID
- ❑Proof of address: Current bill from electricity, gas, etc.
- ❑Proof of income: Most recent paystub, and last filed State / Federal taxes

The information you have provided will be reviewed for eligibility. If you have any questions or need assistance completing this financial statement, please call the billing office at 406.969.6830.

Household Gross Income	Monthly Income
Unemployment Benefit	$
Child Support, alimony/AFDC	$
Social Security/Disability	$
Pension/Retirement/Trust	$
Employment Income	$
Other Income	$
Income last 12 months	$
Income last 3 months	$

I affirm that this statement of gross annual income, liabilities, and assets is true and accurate to the best of my knowledge, and that all statements made by me in this document are true. I understand that the information I have provided is subject to verification by Billings Dermatology.

If approved, I understand if I do not comply with the payment responsibility determined by my financial guidelines, I will be forwarded to collections for the full original balance per office policy.

_____ _____
Signature of Applicant Date

_____ _____
Approved for Sliding Fee Discount ____ / with $25 Min Copay Effective Dates