ROCKY MOUNTAIN SURGICAL CENTER
CHARITY CARE APPLICATION

Please complete all sections of the application.
Once completed, please return, along with requested documents to:
ROCKY MOUNTAIN SURGICAL CENTER
1450 Ellis Street, Suite 101
Bozeman, MT 59715
If you have any questions, please call (406)556-9000

Date of Service:	Chart Number:
Patient Name:	
Guarantor (if different than patient):	
Guarantor's relationship to patient:	
Enter Patient/Guarantor Information Below	
Street Address:	
City, State, Zip:	
Home Phone:	Work Phone:
Employer:	
Employer's Address:	
Spouse:	
Spouse's Employer:	
Spouse's Employer's Address:	
Patient/Guarantor SS #:	Spouse's SS #:

Information on all others living in Patient/Guarantor household
Use additional sheet of paper if necessary

Name	Relation	DOB	Source of Income/Employer	Wage/Week

Surgery Consultants of America, Inc. - 2002 All rights reserved. Intended for the use of SCA clients only.
Distribution beyond the original recipient is prohibited without written permission from Surgery Consultants of America, Inc.

ROCKY MOUNTAIN SURGICAL CENTER
CHARITY CARE APPLICATION
ADDITIONAL INFORMATION REQUIRED

Please return the completed application with all requested information attached.

1. Copy of true, signed income tax return for the previous tax year for each wage earner in the household.

2. If a wage earner did not file a tax return for the previous tax year, a completed "Affidavit of Non-Filing Status" needs to be completed, signed, and notarized.

3. A copy of the last two months' pay stubs for each wage earner currently residing in household.

4. A copy of any letters of unemployment awards issued to anyone currently residing in household.

5. A copy of any disability awards issued to anyone currently residing in household.

6. If anyone currently residing in the household is retired, a copy of any Social Security checks, and/or pension checks, and/or retirement account disbursement checks.

Please add additional information which you feel is necessary to complete our evaluation.

You will be advised as to the status of your application within ten working days of its receipt in our facility. Please feel free to contact us at any time if you have any questions regarding this application.

PLEASE NOTE: *You may be asked to cooperate in an attempt to secure a source of payment outside of this facility in order to cover your account at this facility. These sources may include Medicaid, fraternal organizations, community assistance programs, or any other recognizable charitable organization. Refusal to cooperate may result in denial of this application.*

All of the information received in regard to this application will be held in strictest confidence, per the guidelines set forth in the Federal Patient Bill of Rights.

Signature of Patient/Guarantor:	Date:
Witness of Signature:	Date:

Please feel free to make and keep a copy of this completed form for your own records. If you cannot make a copy, please deliver completed application to the facility and we will make a copy for you.

Surgery Consultants of America, Inc. - 2002 All rights reserved. Intended for the use of SCA clients only.
Distribution beyond the original recipient is prohibited without written permission from Surgery Consultants of America, Inc.