SMC Health Assistance Program Application (HAP)

Name: _____

Please PRINT

Address: _____

Do you have health insurance?_____If yes, what is the name of your Insurance carrier(s)?_____

If you have no health insurance have you applied for Medicaid or Healthy Montana Kids? _____
If yes, when? _____, if No, why?_____

List ALL members of the Family/Household: (include yourself)

Last Name, First Name, MI	Relationship	Birth Date	SSN	Sex	Work Place	Insurance (s)

Financial Status Worksheet:

Family/Household Income	Amount	Weekly, Every other week, Twice a Month, Annually
Wages (Gross)		
Self-Employment		
Unemployment		
Workers Compensation		
Retirement/Pension		
Social Security		
Disability		
Other		
Total		

Initialing the eligibility rules means that you understand and agree to the expectations of the program

___ I may be asked to pay a nominal fee at each visit according to my placement on the sliding scale. If I am unable to pay my entire portion of the bill, I will sign a payment plan at the time of service and make monthly payments.

___ I must provide proof of the total household income to Sweet Medical Center every 12 months and/or if there is a change of status in my income source before the 12 months. I must also fill out a HAP application every year for continued services. I understand that no discounted fees will be applied after eligibility dates have expired.

___ If anyone in my family might qualify for Medicaid, Montana Healthy Kids, or other health insurance, I agree to apply for it. I understand that Sweet Medical Center is the payer of last resort.

___ If I have any health insurance, Medicaid, or Medicare, or other (Dental/Vision) I must give that information to the HAP staff at this time. If at any time in the future I receive private health insurance, Montana Healthy Kids, Medicaid, or Medicare, I must give that information to the HAP staff at the time of service.

Signature: _____ Date_____

I affirm that the information I have given is true and accurate