QUALITY SERVICE
RMC
CARING PEOPLE
Roosevelt Medical Center

PO Box 419
818 2nd Ave. East
Culbertson, MT 59218
406-787-6401
www.rooseveltmedical.org

GUIDE TO FINANCIAL ASSISTANCE

For Services Provided By
Roosevelt Medical Center and Roosevelt Medical Clinic

PAYMENT OPTIONS

At Roosevelt Medical Center, we understand that healthcare expenses may occur when you least expect them and can create a financial burden for you and your family. To assist you through the payment process, Roosevelt Medical Center offers a variety of payment options that are individualized for your needs.

FINANCIAL ASSISTANCE

Roosevelt Medical Center offers financial assistance to individuals who need help with their medical expenses. The process requires completing the attached family assistance plan application. Eligibility is based on income and size of household.

To determine your initial eligibility please refer to the chart on the right. Find the size of your family in the left hand column and look across to see where your total household income falls.

Elective services are excluded from the financial assistance program. Please see the interest free extended payment plan.

Family Size	Annual Income * Percentage that may be adjusted from your bill 100%	75%	50%	25%	0%
1	$15,060	$22,590	$30,119	$30,120	$30,121
2	$20,440	$30,660	$40,879	$40,880	$40,881
3	$25,820	$38,730	$51,639	$51,640	$51,641
4	$31,200	$46,800	$62,399	$62,400	$62,401
5	$36,580	$54,870	$73,159	$73,160	$73,161
6	$41,960	$62,940	$83,919	$83,920	$83,921
7	$47,340	$71,010	$94,679	$94,680	$94,681
8	$52,720	$79,080	$105,439	$105,440	$105,441

* The complete sliding fee schedule is on the application form.

Interest Free Extended Payment Plan

Roosevelt Medical Center offers an interest free payment plan for up to 24 months. Typically a $50 minimum payment is required.

Payment Schedule If your Balance is			# of Monthly Payments Balance in full
$1.00	to	$100.00	6
$100.01	to	$600.00	12
$600.01	to	$1,200.00	15
$1,200.01	to	$2,400.00	18
$2,400.01	to	$3,000.00	21
$3,000.01	to	$4,000.00	24
$4,000.01	to	and up	

Medicaid & the Children's Health insurance Program (CHIP) offer free or low cost health coverage to children and families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage.
For information contact: Website: http://apply.mt.gov/

For states other than Montana contact U.S. Department of Labor Website: www.dol.gov/ebsa or call 1-866-444-3272

If you need help in filling out the information please contact the business office at Roosevelt Medical Center.

Roosevelt Medical Center PO Box 419 Culbertson, MT 59218 Phone: 406-787-6401

Financial Assistance Plan Application

Name:				
STREET	CITY	STATE	ZIP	PHONE

Please list all household members, including those under age 18. Family is defined as: a group of two people or more (one of who is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. RMC will also accept non-related household members when calculating family size.

Name	Date of Birth	Name	Date of Birth
Self		DEPENDENT	
Spouse		DEPENDENT	
DEPENDENT		OTHER	
DEPENDENT		OTHER	

Please use the back of the form if you need more room for other occupants of your household.

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				$0.00
Income from business and self-employment.				$0.00
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income.				$0.00
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.				$0.00
Rent, interest, dividend, and other income				$0.00
Total Income				$0.00

I certify that the family / household size and income information shown above is correct. Copies of tax returns, pay stubs and other information verifying income may be required before a discount is approved.

Name (print) _____ Date _____

Signature _____

Office Use Only

Patient Name		Discount	
Date of Service		Approved by	

Verification Checklist (attach Copies	YES	NO
Identification/Address: Drivers' license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		

ROOSEVELT MEDICAL CENTER
SLIDING FEE SCHEDULE
BASED ON FEDERAL INCOME POVERTY GUIDELINES

Poverty Level *	100%	101% to 150%		151% to 199%		200%	>200%
	Discount %						
Family Size	100%**	75%		50%		25%	0%
	Maximum	Minimum	Maximum	Minimun	Maximum	Maximum	
1	$15,960	$15,961	$23,940	$23,941	$31,919	$31,920	$31,921
2	$21,640	$21,641	$32,460	$32,461	$43,279	$43,280	$43,281
3	$27,320	$27,321	$40,980	$40,981	$54,639	$54,640	$54,641
4	$33,000	$33,001	$49,500	$49,501	$65,999	$66,000	$66,001
5	$38,680	$38,681	$58,020	$58,021	$77,359	$77,360	$77,361
6	$44,360	$44,361	$66,540	$66,541	$88,719	$88,720	$88,721
7	$50,040	$50,041	$75,060	$75,061	$100,079	$100,080	$100,081
8	$55,720	$55,721	$83,580	$83,581	$111,439	$111,440	$111,441
For each addtional person, add	$5,680						

*Based on 2025 HHSA Poverty Guidelines (http://aspe.hhs.gov/poverty)