



BUCKETS OF LOVE, INC

PO Box 3104
Missoula, MT 59806
406-272-5522
contact@bucketsoflove.net

Financial Assistance Application Form Instructions

Buckets of Love, Inc. partners with healthcare and mental healthcare providers to help you access mental health services, affordably. You may qualify for free care or reduced-price care based on your family size and/or income, even if you have health insurance. To view our financial assistance policy please go to

<https://www.bucketsoflove.net>.

To apply for Montana Medicaid, please go to <https://medicaid-help.org/>

In order for your application to be processed, you must:

- ♥ **Provide us information about your family**
Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- ♥ **Provide us information about your family's gross monthly income**
(income before taxes and deductions) to include pay stubs, W-2 forms, tax returns, social security award letters, etc.
- ♥ **Provide documentation for family income and declare assets**
- ♥ **Attach additional information if needed**
- ♥ **Sign and date the financial assistance form**

Mail completed application with all documentation to: Buckets of Love, Inc., PO Box 3104, Missoula, MT 59806, or email it to application@bucketsoflove.com. Be sure to keep a copy for yourself.

We will notify you of the final determination of eligibility within 30 days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

**We want to help. Please submit your application promptly!
You may receive bills from your provider until your
application has been reviewed and approved.**

Please fill out all information completely. If it does not apply, write "NA". Attach additional pages if needed.

If financial assistance is awarded, you will have 30 days to locate a provider that agrees to accept the terms of the application.

SCREENING INFORMATION

Do you need an interpreter? Yes No If Yes, list preferred language:

Has the applicant applied for Medicaid? Yes No

Does the applicant receive state public services such as TANF, Basic Food, or WIC? Yes No

Is the applicant currently homeless? Yes No

Is the applicant 25 years of age or younger? Yes No

Is the applicant 26 years of age or older? Yes No

PLEASE NOTE

*We cannot guarantee you will qualify for financial assistance

*Once you submit your application, we may check all the information and may ask for additional information or proof of income

*Within 30 days after we receive your completed application and documentation, we will notify you if you are eligible for assistance

FINANCIAL ASSISTANCE APPLICATION FORM – (CONFIDENTIAL)

APPLICANT INFORMATION

<u>Applicant First Name</u>	<u>Applicant Middle Name</u>	<u>Applicant Last Name</u>			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____) <input type="checkbox"/> Pronoun (may specify _____)					
Birth Date: _____		Social Security Number: _____			
Person Responsible for Paying Bill:					
Relationship to Applicant: _____					
Birth Date: _____					
Mailing Address:			Main Contact Phone Numbers:		
_____			Ph. # ()		
_____			Ph. # ()		
Email Address of Responsible Party: _____					
Employment status of Responsible Party (parent or guardian):					
Employed: _____		Date of Hire : _____	Self-employed: _____		
Unemployed _____		Length of unemployment: _____	Student: _____		
Disabled: _____		Retired: _____	Other: _____		
List all members of your household, including you.					
<u>Family Size:</u>		Attach additional pages if needed			
<u>Name</u>	<u>DOB</u>	<u>Relationship</u>	<u>If 18 years or older</u> <u>Name of Employer</u> <u>or source of income</u>	<u>Gross</u> <u>Monthly Inc.</u>	<u>Also applying</u> <u>for Fin Assist</u>
					Y N_
					Y N_
					Y N_
					Y N_
					Y N_
					Y N_
					Y N_
					Y N_
					Y N_
All family members' income must be disclosed. Sources of income include, for example: Wages, Self-employment, Unemployment, Workers Compensation, Disability, SSI, Child/Spousal Support, Work Study programs (students), Pension and Retirement account distribution.					

Other: _____

You must provide information on your family's income. Income verification is required to determine financial assistance eligibility. All family members must disclose their income.

If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:

Preferred Current pay stubs (3 months)

Last year's income tax return, including schedules if applicable;

Written, signed statements from employers or others;

Required: Approval/denial of eligibility for Medicaid and/or state-funded medical assistance;

Approval/denial of eligibility for unemployment compensation.

Proof of state-funded assistance

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

Monthly Household Expenses:

Rent/Mortgage \$ _____ Medical expenses \$ _____

Insurance Premiums \$ _____ Utilities \$ _____

Other Debt/Expenses \$ _____ (child support, loans, medications, other)

ASSET INFORMATION

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

Current checking account balance

\$ _____

Current savings account balance

\$ _____

Does your family have these other assets?

Please check all that apply

Stocks Bonds 401K Health Savings Account(s) Trust(s)

Property (excluding primary residence) Own a business

INSURANCE INFORMATION

Insurance Company: _____

Policy Number: _____ Group Number: _____

Deductible: \$ _____

Deductible Met: \$ _____

Mental Health Services Copay: \$ _____

Current Medical Provider: _____

Phone Number: _____

Address: _____

Current Mental Health Provider: _____

Phone Number: _____

Address: _____

