



Name: \_\_\_\_\_ Resident # \_\_\_\_\_ Admission Date \_\_\_\_\_

STATE OF MONTANA  
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES  
525 East Mercury Street  
Butte MT 59701

Montana Veterans Home  
Montana Developmental Center  
Montana State Hospital  
Montana Chemical Dependency Center  
Montana Mental Health Nursing Care Center

### **CONFIDENTIAL FINANCIAL STATEMENT**

Montana law provides that a resident and/or financially responsible person is liable for the resident's cost of care in a state institution in an amount the department determines the resident or financially responsible person is able to pay. The department determines a person's ability to pay and the amount of required monthly payments based upon financial information and documentation obtained through a financial investigation authorized by state law. Sections 53-1-401 through 414, Montana Code Annotated.

### **Instructions**

Any person admitted to a State of Montana public institution for care, his or her spouse, or other responsible person must complete the form.

**Please answer all questions. This will assist in making a fair evaluation in determining your ability to pay for cost of care. If the answer is "none", write "none".** If more space is needed, please attach a separate sheet.

**In order to make a fair evaluation, you must include copies of the following information/documentation:**

- |  |  |  |
|--|--|--|
| Income verification for resident,<br>resident's spouse, and dependents | Copy of Guardianship document          | Individual retirement accounts (IRA)   |
| Birth certificates   | Copy of Conservator document           | Mutual funds   |
| Social Security cards  | Burial policies                        | Annuities/ 401-K Plans   |
| Medicare supplemental health insurance card                            | Life insurance policies                | Deferred compensation accounts   |
| Medicare card  | Current checking account statement     | Outstanding medical bills  |
| Medicaid card  | Current savings account statement      | Housing expenses   |
| Health insurance card  | Current money market account statement | Court-ordered debt   |
| Copy of Power of Attorney document                                     | Certificates of deposit                |  |
|  | Stocks / Bonds                         | Any other financial information needed<br>that may affect the determination of<br>cost of care |

IF YOU CHOOSE NOT TO COMPLETE THIS FORM, YOU WILL BE RESPONSIBLE FOR PAYING THE FULL COST OF CARE. YOU WILL BE BILLED MONTHLY AND AGREE TO PAY THE BILL IN FULL UPON RECEIPT. PLEASE SIGN AND DATE BELOW.

**I CHOOSE TO PAY FULL COST OF CARE:**

Signature

Date

Resident name: \_\_\_\_\_

Name of facility: \_\_\_\_\_

Admission date: \_\_\_\_\_

Re-evaluation date: \_\_\_\_\_

**PART 1 DEMOGRAPHIC INFORMATION**

**RESIDENT/PATIENT INFORMATION**

**Resident/Patient:** \_\_\_\_\_ **Resident#** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Branch of military service:** \_\_\_\_\_

**Date of military service:** From \_\_\_\_\_ To \_\_\_\_\_

**Marital status:** \_\_\_\_\_

**Serial number:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Veterans Administration claim number:** \_\_\_\_\_

**Social Security number:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Home phone:** \_\_\_\_\_

**Currently employed:** \_\_\_\_\_

**Message phone:** \_\_\_\_\_

**How long employed:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Employer name:** \_\_\_\_\_

**Probation or parole:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Address:** \_\_\_\_\_

**Name of probation officer:** \_\_\_\_\_

**Work phone:** \_\_\_\_\_

**If unemployed, date last worked:** \_\_\_\_\_

**Remarks:** \_\_\_\_\_  
\_\_\_\_\_

**Insurance** – Please provide copies of all medical identification cards (front and back) and copies of burial contracts.

**Medicare/Medicaid**

**Medicare** number: \_\_\_\_\_

**Medicaid** number: \_\_\_\_\_

Part A effective date: \_\_\_\_\_

Passport physician: \_\_\_\_\_

Part B effective date: \_\_\_\_\_

Phone: \_\_\_\_\_

Part D effective date: \_\_\_\_\_ Part D name: \_\_\_\_\_

Part D Number \_\_\_\_\_ MHSP: \_\_\_\_\_

**Health Insurance**

**Primary insurance:** \_\_\_\_\_

Company address: \_\_\_\_\_

Group number: \_\_\_\_\_

Policy number: \_\_\_\_\_

Policy owner: \_\_\_\_\_

**Secondary insurance:** \_\_\_\_\_

Company address: \_\_\_\_\_

Group number: \_\_\_\_\_

Policy number: \_\_\_\_\_

Policy owner: \_\_\_\_\_

**Burial Contracts**

Name of funeral home: \_\_\_\_\_

Address: \_\_\_\_\_

Other type of burial account (describe): \_\_\_\_\_

Address: \_\_\_\_\_

**Spouse or financially responsible person**

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Self-employed: Yes \_\_\_\_\_ No \_\_\_\_\_

If unemployed, date last worked: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Veteran \_\_\_\_\_

Date of birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Home phone: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Probation or parole: Yes \_\_\_\_\_ No \_\_\_\_\_ Name of probation officer: \_\_\_\_\_

Remarks: \_\_\_\_\_

**Representative payee, guardian, conservator, power of attorney, trustee, other financially responsible person**

Name: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Business or agency name: \_\_\_\_\_

**Dependents of resident/patient (as reported on income tax returns)**

Name	Relationship	Age	Residing with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Remarks: \_\_\_\_\_

**PART 2 INCOME If self-employed, provide complete copy of latest federal tax return**

Are you or a family member involved in a lawsuit that may end in a financial settlement? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you or a family member have any applications pending that may result in a retroactive cash benefit? Yes \_\_\_\_\_ No \_\_\_\_\_

Name, address and phone number of attorney: \_\_\_\_\_

If you have answered yes to either question above, please explain: \_\_\_\_\_

Part 2 continued:

<u>Type of Income</u>	<u>Resident/Patient</u>	<u>How often paid (weekly, bi-weekly monthly, yearly)</u>	<u>Spouse</u>	<u>How often paid (weekly, bi-weekly monthly, yearly)</u>
<u>Wages</u> (take home)	\$ _____	_____	\$ _____	_____
<u>Social Security</u>	\$ _____	_____	\$ _____	_____
<u>Civil Service</u>	\$ _____	_____	\$ _____	_____
<u>Veterans</u> <u>Service connected</u>	\$ _____	_____	\$ _____	_____
<u>Veterans</u> <u>Non-service connected</u>	\$ _____	_____	\$ _____	_____
<u>Railroad Retirement</u>	\$ _____	_____	\$ _____	_____
<u>Pensions/Annuities/Retirement</u>	\$ _____	_____	\$ _____	_____
<u>Unemployment / Workman's     <u>Compensation</u></u>	\$ _____	_____	\$ _____	_____
<u>Alimony/Child support</u>	\$ _____	_____	\$ _____	_____
<u>Rental income</u>	\$ _____	_____	\$ _____	_____
<u>Dividends</u>	\$ _____	_____	\$ _____	_____
<u>Interest</u>	\$ _____	_____	\$ _____	_____
<u>Trusts</u>	\$ _____	_____	\$ _____	_____
<u>BIA (Indian income/per capita)</u>	\$ _____	_____	\$ _____	_____
<u>Royalties</u>	\$ _____	_____	\$ _____	_____
<u>Inheritance</u>	\$ _____	_____	\$ _____	_____
<u>Escrow</u>	\$ _____	_____	\$ _____	_____
<u>Dependent Income</u>	\$ _____	_____	\$ _____	_____
<u>Other income</u>	\$ _____	_____	\$ _____	_____
 <b>TOTAL INCOME</b>	 \$ _____		 \$ _____	

**PART 3 LIQUID ASSETS**

Type of Asset	Name/Address of Bank/ Institution	Remarks	Jointly held		Balance of Account
			Yes	No	
<u>Checking</u>	Name of institution: _____ Address: _____		___	___	\$ _____
	Name of institution: _____ Address: _____		___	___	\$ _____
<u>Funds held by representative payee</u>	Name of institution: _____ Address: _____		___	___	\$ _____
<u>Account balance at Facility / cash on hand</u>	Name of institution: _____		___	___	\$ _____
<u>Savings</u>	Name of institution: _____ Address: _____		___	___	\$ _____
<u>Credit Union</u>	Name of institution: _____ Address: _____		___	___	\$ _____
<u>Bank Certificates of Deposit (CD's)</u>	Name of institution: _____ Address: _____	Maturity date: _____	___	___	\$ _____
<u>Stocks</u>	Name of stock: _____ Purchase date: _____	# shares: _____	___	___	\$ _____
	Name of stock: _____ Purchase date: _____	# Shares: _____	___	___	\$ _____
<u>Bonds</u>	Name of bond: _____		___	___	\$ _____
	Name of bond: _____		___	___	\$ _____
<u>Money Market</u>	Name of company: _____		___	___	\$ _____
<u>Mutual Funds</u>	Name of company: _____		___	___	\$ _____
<u>Life Insurance</u>	Company name: _____ Policy number: _____ Address: _____ Beneficiary: _____	Whole life: _____ Term life: _____ Face value: _____ \$ _____			Cash value \$ _____
	Company name: _____ Policy number: _____ Address: _____ Beneficiary: _____	Whole life: _____ Term life: _____ Face value: _____ \$ _____			Cash value: \$ _____
<u>Deferred Compensation</u>	Name of institution: _____ Address: _____	Accessible Yes ___ No ___			\$ _____
<u>Pension, Retirement, Annuities</u>	Name of institution: _____ Address: _____	Accessible Yes ___ No ___			\$ _____

Part 3 continued:

Type of Asset	Name/Address of Bank/ Institution	Remarks	Jointly held		Balance of Account
			Yes	No	
<u>Vehicles</u>	<b>Vehicle #1</b>				
	Year/model: _____	Market value:			Balance owing:
	Lending institution: _____	\$ _____			\$ _____
	<b>Vehicle #2</b>				
	Year/model: _____	Market value:			Balance owing:
	Lending institution: _____	\$ _____			\$ _____
<u>Escrow</u>	Name of institution: _____	Maturity date:			
	Address: _____	_____			\$ _____
<u>Real Estate</u>	Location: _____	Market value:			Balance owing:
<u>Real Property</u>	_____	\$ _____			\$ _____
	Other property: _____	Market value:			Balance owing:
	_____	\$ _____			\$ _____
<u>Other assets: oil</u>	Kind of asset: _____				
<u>rights mineral</u>	Name of institution: _____				
<u>timber,livestock</u>	Address: _____				\$ _____

<b>PART 4    FIXED EXPENSES    Please designate how often paid</b>
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**Housing expenses**

Landlord name: _____	Heat: _____
Address: _____	Electricity: _____
Phone number: _____	Phone (basic rate): _____
Rent/lease payment: _____	Cable TV: _____
Mortgage payment: _____	Water/sewer: _____
If taxes and insurance are not included in mortgage payment, list amounts:	Garbage: _____
Property taxes: _____	Storage unit: _____
Property insurance: _____	Post office box rent: _____
Miscellaneous other expenses (explain): _____	
_____	

<b>Office Use Only: Standard government food and clothing allowance    Food: \$ _____    Clothing: \$ _____</b>
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**TOTAL HOUSING EXPENSES: \$ \_\_\_\_\_**

Part 4 continued:

**Transportation**

**Vehicle #1** Make: \_\_\_\_\_ Year \_\_\_\_\_  
 Loan payment: \_\_\_\_\_  
 Date paid off: \_\_\_\_\_  
 Balance owing: \_\_\_\_\_  
 Insurance premium: \_\_\_\_\_  
 License registration: \_\_\_\_\_  
 Maintenance: \_\_\_\_\_  
 Fuel: \_\_\_\_\_

**Vehicle #2** Make: \_\_\_\_\_ Year \_\_\_\_\_  
 Loan payment: \_\_\_\_\_  
 Date paid off: \_\_\_\_\_  
 Balance owing: \_\_\_\_\_  
 Insurance Premium \_\_\_\_\_  
 License registration: \_\_\_\_\_  
 Maintenance: \_\_\_\_\_  
 Fuel: \_\_\_\_\_

If you do not own a vehicle, monthly expense for public transportation (i.e., taxi, city bus): \_\_\_\_\_

Remarks: \_\_\_\_\_

**TOTAL TRANSPORTATION EXPENSES:** \$ \_\_\_\_\_

**Other fixed expenses** (If any expenses are deducted from your paycheck, please do not report them)

Medical insurance premium: \_\_\_\_\_  
 Life insurance premium: \_\_\_\_\_  
 Burial account payment: \_\_\_\_\_  
 Day care: \_\_\_\_\_  
 Safe deposit box: \_\_\_\_\_  
 Representative payee fees: \_\_\_\_\_  
 Miscellaneous other expenses (explain): \_\_\_\_\_

Court-ordered debt: \_\_\_\_\_  
 (Child support/alimony, fines, restitution, etc.)  
 When due: \_\_\_\_\_  
 To be paid off when: \_\_\_\_\_  
 Balance owing: \_\_\_\_\_  
 Union / Lodge dues: \_\_\_\_\_

**TOTAL OTHER EXPENSES:** \$ \_\_\_\_\_

**Medical expenses** (Itemized on-going and unpaid medical/mental health expenses: Doctor, dental, hospital, eye care pharmacy, ambulance, etc.)

<u>Name of provider:</u>	<u>City, State:</u>	<u>Monthly payment</u>	<u>Balance owing</u>
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____

Remarks: \_\_\_\_\_

**TOTAL MEDICAL PAYMENTS:** \$ \_\_\_\_\_

**TOTAL EXPENSES:** \$ \_\_\_\_\_

Montana Veterans Home  
Montana Developmental Center  
Montana State Hospital  
Montana Chemical Dependency Center  
Montana Mental Health Nursing Care Center

I declare that the information on this financial statement is accurately given to the best of my knowledge. I hereby authorize a release to the Department of Public Health and Human Services to obtain / release financial information, which may be necessary in order to arrive at an equitable evaluation of ability to pay for care received.

**Resident name:** \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

Relationship to resident: \_\_\_\_\_

Indicate if you are:

Guardian \_\_\_\_\_ Conservator \_\_\_\_\_ Power of Attorney \_\_\_\_\_ Representative Payee \_\_\_\_\_ Trustee \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_  
(Signature of resident or financially responsible person) Date

\_\_\_\_\_  
(Financial Investigator) Date

**Peggy Bennetts Financial Investigator**  
DPHHS - Reimbursement  
Montana Chemical Dependency Center  
525 East Mercury Street  
Butte MT 59701  
Phone: 406-496-5407  
Fax: 406-496-5434