Financial

Back to the Home Page

Financial Assistance Programs based on MONTHLY income 2017

	EMERGENCY	FOOD		UTILITIES	HOUSING	PROPERTY TAX RELIEF		FREE HEALTH	PRESCRIPTION HELP		MEDICAID HELPS WITH MEDICARE EXP.		
# in House	(TANF) Temporary Aid to Needy Families	SNAP (food stamps) Resources under $3000 (if over 60) $2000 for all others	Flathead Food Bank Senior Commodities Box once per month	(LIEAP) Energy Assistance (There are resource limits-see application)	Flathead HUD housing	(PTAP) Property Tax Assistance Program 20% 50% 70%	Disabled Veterans Property Tax Benefits	Shepherd's Hand Free Medical and Dental Clinic www.shepherdshand.com (Mon.6 pm -first come/first served at WF Christ Lutheran Church) 200% of povery level	Big Sky RX prescription assistance	Medicare "Extra Help" for prescription plan premiums	Medicare Savings Program-Qualified Medical Beneficiary (QMB)(There are resource limits-see application)	Medicare Savings Program-Special Low Income Medical Beneficiary (SLMB) (There are resource limits-see application)	Medicare Savings Program-Qualified Medical Beneficiary (QI) (There are resource limits-see application)
1	642	1962	1287	1857	2821	701 20%	<4096	2010	1980	1507	1010	1208	1357
2	867	2655	1736	2429	3221	935 20%	<4727	2706	2670	2030	1355	1622	1823
3	1092	$3,349	2184	3001	3625			3403					
4	1317	4042	2633	3572	4025			4100					
5	1542	$4,735	3001	4144	4350			4796					
6	1767	5429	3530	4715	4671			5493					
7	1992	$6,122	3979	4823	4992			6190					
8	2217	6815	4430	5111	5317			6886					
9		693 per	451 per	5631									
10		added	added	6151									
Fiscal year		**1-Oct**	**1-Apr**	**10/1-4/30**	**1-Apr**	**1-Jan**		**1-Jan**	**1-Jan**	**1-Jan**	**1-Jan**	**1-Jan**	**1-Jan**
Where apply:	**OPA dphhs.mt.gov/hcsd/TANF**	**OPA dphhs.mt.gov/hcsd/SNAP**	**flatheadfoodbank.com/**	**CAPNM**	**CAPN or housing.mt.gov**	**https://revenue.mt.gov/propertytax-relief**		**Go in Person 5150 River Lakes Parkway, Whitefish**	**rxresource.org**	**ssa.gov/medicare/prescriptionhelp/**	**https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html**		

OPA=Office of Public Assistance 121 Financial Dr. Kalispell 751-5900

CAPN=Community Action Partner NW Montana 214 Main St. Kalispell 752-6565

PROGRAM DESCRIPTIONS:

Temporary Aid to Needy Families (TANF) is a program that helps families with children.

SNAP (food stamps) provides a debit card for groceries for eligible families.

ENERGY ASSISTANCE PROGRAMS

Website: www.capnm.net

E-Mail: lieap@capnwmt.org

Flathead County: 214 Main Street, PO Box 8300, Kalispell, MT 59904
406-758-5433, 800-344-5979, NEW Fax-406-206-0199

Lake County: 110 Main Street, Mezzanine Level, PO Box 132, Polson, MT 59860
406-883-3470, Fax-406-883-3481

Lincoln County: 933 Farm To Market Rd, Suite B, Libby, MT 59923
406-293-2712, Fax-406-293-2979

Sanders County: 2504 Tradewinds Way, #1, Thompson Falls, MT 59873 (Job Service)
406-827-3472, Fax-406-827-3327

For referrals to other counties around the State of Montana, call the Governor's office at 800-332-2272.

This is a brief overview of the energy programs administered by Community Action Partnership of Northwest Montana (CAPNM).

Low-Income Energy Assistance Program (LIEAP) **-** LIEAP assists households in paying for winter home heating. Assistance may be available for a portion of the primary heating costs incurred between October 1 and April 30 of each program year. Applications may be picked up at any of our offices, mailed, e-mailed or downloaded from our website between October 1 and April 30. A required item "check list" is included in the application and on our website.

2017-2018 LIEAP/Weatherization Income & Resource Limits

Household Members	LIEAP ~ Annualized Income	LIEAP ~ 1 Month Income	Resources (excludes home, vehicles, personal items, & most retirement accounts)	Weatherization ~ Annualized Income
1	$22,712	$1,892	$11,160	$24,120
2	$29,700	$2,475	$16,744	$32,480
3	$36,688	$3,057	$17,861	$40,840
4	$43,676	$3,639	$18,978	$49,200
5	$50,664	$4,222	$20,095	$57,560
6	$57,652	$4,804	$21,212	$65,920
7	$58,962	$4,913	$22,329	$74,280
8	$61,980	$5,165	$22,329	$82,640
9	$68,250	$5,687	$22,329	$91,000
10	$74,520	$6,210	$22,329	$99,360

MORE INFORMATION ON BACK

Emergency Heating System Repair and/or Replacement **–** Assistance may be available for the repair; or in some cases, replacement; of the primary heating system for a homeowner if it is not working properly or poses a threat to the health and/or safety of the household members. If you experience an emergency with your primary heating system after business hours and do not have back up heat, you may contact our on-call personnel at 406-261-6524.

Weatherization Assistance Program **–** Weatherization helps reduce the high cost of energy for low-income households. An energy auditor evaluates the home's energy efficiency and makes recommendations of the measures that could be done to the home to provide the biggest energy savings. Based upon those recommendations, a combination of weatherization measures such as wall, attic, and floor insulation may be installed, doors and windows may be repaired to reduce air infiltration, and efficiency and safety measures on home heating systems may be performed. In some cases, new heating systems may be provided to further the energy efficiency of the home. Each LIEAP approved household is prioritized based upon their annual income and the amount they spend on heating bills. Priority lists are updated throughout the year and a household must apply for and continue to be approved for LIEAP each year to remain on the priority list. Homes with low income and high heating bills are top priority with special consideration given to households which contain elderly and/or disabled individuals. Upon reaching the top of the priority list, the household is contacted to set up an appointment to conduct an energy audit. For more information, call the **Weatherization Department directly at 406-755-7363 or 888-750-7360.**

Low-Cost Materials (LCNC) **–** LIEAP approved households may receive materials such as plastic window kits, weather stripping, roof patch, door sweeps, pipe wrapping, energy efficient light bulbs, and other low cost items they can install in their home to seal out drafts and to make it more comfortable and energy efficient. To receive LCNC supplies, an applicant must be approved for LIEAP and request materials from their LIEAP office.

Energy Share of Montana **–** Energy Share of Montana helps Montana residents faced with energy emergencies meet their need and move toward self-reliance. Eligibility for Energy Share is not determined solely on income but also on the extenuating circumstances a household is facing. Energy Share is primarily funded by State-mandated Universal System Benefits Program (USBP) charges, donations from private individuals and corporations, and repayments by previous recipients.

Energy Savings Program - Energy Share of Montana may also assist with replacement of an inefficient refrigerator or a non-working water heater. REFRIGERATOR requirements ~ household member 60+ years of age or disabled by Social Security standards, own your home and have an older, inefficient refrigerator. WATER HEATER requirements ~ own your home and have a non-working water heater.

In addition to the assistance programs listed, we work with vendors to provide discounts or other programs to low-income households. Most vendors require that an applicant qualify for LIEAP services and be referred by the local CAPNM office.

Information and brochures on ways you can improve the comfort level of your home, conserve energy and lower your heating costs are available upon request.

For further information on any of these programs or to obtain an application, please contact CAPNM. If you do not meet the income limits, we may be able to look at alternatives to get you qualified.

FOR MORE INFORMATION CONTACT CAPNM
406-758-5433 or 800-344-5979
E-MAIL: lieap@capnwmt.org

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

Dear Energy Assistance Program Applicant:

This is an equal opportunity program. Discrimination is prohibited. Please find attached an application for the Low Income Energy Assistance Program (LIEAP) and Weatherization. To apply for the LIEAP program, this application must be completed and returned to your local LIEAP office by April 30, 2018. LIEAP heat assistance applications will **not** be accepted after April 30, 2018. You can apply for Weatherization all year. You can only apply for LIEAP benefits and Weatherization for the dwelling you reside in at the time of application. If you move you must file another application.

Please complete all of the information in each section of the LIEAP/Weatherization application. **You must also provide verification of all gross income received by current household members within the six (6) months prior to the month you turn in your application (please refer to the table below) and a copy of your most recent heating fuel bill.** Your application for LIEAP/Weatheriztion assistance cannot be processed without this verification. If everyone in the household receives SNAP please contact your local LIEAP/Weatherization office. **Failure to provide all requested information and verifications will delay the eligibility determination and may result in application denial.** LIEAP/Weatherization eligibility will be determined based upon the circumstances at the time of application.

Note: All adult household members who live on a reservation (other than the Crow Reservation), and who are Native American, enrolled tribal members or direct descendants should contact their Tribal LIEAP office for assistance. Native American household members who live on the Crow reservation should contact District VII Human Resource Development Council (Billings) for assistance.

If you or a household member is over the age of 60, or a person with a disability, call 1-800-551-3191 for help filling out this application.

If you turn in your application in the month of:	Provide verification of income for these months:
August 2017	February 2017 through July 2017
September 2017	March 2017 through August 2017
October 2017	April 2017 through September 2017
November 2017	May 2017 through October 2017
December 2017	June 2017 through November 2017
January 2018	July 2017 through December 2017
February 2018	August 2017 through January 2018
March 2018	September 2017 through February 2018
April 2018	October 2017 through March 2018

Please provide your most recent heat and electric bill(s). Many utility and heat vendors provide discounts to LIEAP eligible households.

There is help available through your local LIEAP office if your primary heat source (furnace) is not working.

If you have any questions regarding your LIEAP/Weatherization application, please call your local LIEAP/Weatherization office. The contact number for the local LIEAP/Weatherization office that serves the county that you live in is listed on the last page of the application.

When your LIEAP/Weatherization application is complete, please send the application along with the necessary verification to your local LIEAP/Weatherization office. The address for the LIEAP/Weatherization office that serves the county that you live in is listed on the last page of the application. **If you move anytime after submitting an application, please contact your LIEAP/ Weatherization office.**

APPLICANT RIGHTS AND RESPONSIBILITIES

Rights:

To inquire and be informed about conditions of eligibility, scope of the program and related services available, including regular and emergency benefits.

To be determined eligible or ineligible based upon the information and corresponding documentation provided for the completed application.

To receive timely written notice of denial, reduction, or termination of assistance.

To be informed of the Fair Hearing process.

To have a confidential relationship.

To have your Civil Rights protected.

Responsibilities:

To complete the application.

To sign a "Release of Confidential Information" form. (Everyone in the household who is 16 years of age or older.)

To provide proof of income for all household members.

To provide child support verification including non-court ordered child support.

To report changes in your physical and/or mailing address within 10 days.

To provide verification of SSN, proof of citizenship or lawful entry into the U.S. with the intent of establishing permanent residency, for all household members.

If unable to provide SSN, provide photo identification for all household members over the age of 18. For household members under age 18, a birth certificate must be provided if you don't have a photo ID.

To provide verification of all bank accounts and other resources.

To provide your most recent heat and electric bill(s).

If you wish to make any comments regarding any special situation, or you wish to clarify any of your responses, please do so on a separate piece of paper.

APPLICATION CHECKLIST:

[X] Make sure you have done the following things:

- ☐ Completed all sections on the application, especially Income in Section 6 and each Resource line in Section 7.
- ☐ Completed physical and mailing address information.
- ☐ Ensured all people who reside in the dwelling are included on the application.
- ☐ Ensured that all household members 16 years of age or older have signed Section 9.
- ☐ Included a copy of your most recent heat and electric bill(s) indicated in Section 4.
- ☐ Included copies of proof of all gross incomes received in the past six (6) months, from all sources (including Child Support, Worker's Comp and VA), for all members of the household regardless of the age or relationship. Social Security and SSI recipients may be required to provide a copy of SSA award letter or SSA 1099 form.
- ☐ Included copies of proof of all out of pocket health insurance premiums paid by a household member for a household member.
- ☐ Included copies of all supporting documentation of all current resources you reported in Section 7, including a recent full bank statement(s) for all household member's accounts, reliacard, and direct express verification.
- ☐ Included a copy of photo ID for all household members. Include copies of birth certificates for household members under 18 years of age who don't have photo IDs.
- ☐ Included a copy of Social Security Number, proof of citizenship or qualified alien status as defined by 8 U.S. Code 1641(b).
- ☐ Checked the address list on page 9 for mailing your completed application to the correct LIEAP eligibility office.
- ☐ Notify the agency if you need assistance to complete a LIEAP Application.

STATE OF MONTANA - Department of Public Health and Human Services

October 1st - April 30th (Heat bill assistance applications will not be accepted after April 30th)

LOW-INCOME ENERGY ASSISTANCE AND WEATHERIZATION PROGRAM APPLICATION

NOTE: YOU WILL RECEIVE A LETTER TELLING YOU WHETHER YOU ARE ELIGIBLE AFTER WE RECEIVE YOUR COMPLETED APPLICATION. YOUR APPLICATION CANNOT BE PROCESSED WITHOUT ALL OF THE INFORMATION REQUESTED.

Section 1 HOUSEHOLD ADDRESS INFORMATION

This application is for LIEAP benefits/Weatherization for the dwelling resided in at the time of application.

Physical Address where currently living:

Address Line 1:

Address Line 2:

City:

State: **Zip Code:**

County:

Date Moved to this Address if within the last 12 months: / /

Was Previous Address out of State (Y/N):

Mailing Address:

Line 1:

Line 2:

City:

State: **Zip Code:**

Home Phone # : ( ) -

Message Phone # : ( ) -

Section 2 HOUSEHOLD MEMBERS (List everyone who lives in this residence.)

Provide all requested information for all persons living in the house regardless of relationship whether or not you consider them a household member.

(NOTE: Entries for gender, Hispanic, and race are not required. Photo IDs and SSN(s) are required for all household members. If you do not have Social Security Number(s) you must provide alternate identification for all such household members. (e.g. Proof of citizenship, lawful entry into the U.S. or birth certificates for children up to 18 years of age).

Relationship : SE Head of Household(self); **SP** Spouse/Significant Other; **CH** child; **GC** Grandchild; **FC** Foster Child; **PA** Parent; **SB** Sister/Brother; **AU** Aunt/Uncle; **NN** Niece/Nephew; **CO** Cousin; **EX** Ex-Spouse; **NR** Not Related; **OR** Other Related. **Hispanic Status : HL** Hispanic/Latino; **NH** Not Hispanic/Latino. **Race Status :**(Multiple Selections Allowed): **W** White; **B** Black/African American; **AI** American Indian/Alaska Native; **AS** Asian; **P** Native Hawaiian/Pacific Islander. **Health Insurance Status :**(Multiple Selections Allowed): **MA** Medicaid; **MC** Medicare; **PV** Private; **CH** Healthy Montana Kids ;**VA** Veterans Administration; **OT** Other; **NN** None. **Highest Grade Completed : 0** None; **1-6** Grades 1-6; **7-8** Grades 7-8; **9-11** Grades 9-11; **AS** Associate; **BA** Bachelor; **BK** Before Kindergarten; **GED** GED Completed; **HS** High School Completed; **K** Kindergarten; **MS** Master; **PR** Professional; **VT** Vo-Tech. **Employment Status : FT** Full Time; **PT** Part Time; **NE** Not Employed; **RT** Retired/Not Working.

For Office Use Only: Application Received Date

Total # Members in the Household:

Last Name: **Age:**

First Name: **Birth Date:** / / **Household Relationship(see list above for values):**

Mid Init: **SSN:** - - **Gender(M/F):** **Veteran (Y/N):** **Disabled(Y/N):**

Alias Last Name: **Hispanic Status:** **In School(Y/N):** **In Literacy Training (Y/N):**

Alias First Name: **Highest Grade(see list above):** **Employment (see list above):**

Health Insurance (see list above): MA ☐ MC ☐ PV ☐ CH ☐ OT ☐ NN ☐ VA ☐

Work Phone # : ( ) -

Race (see list above): W ☐ B ☐ AI ☐ P ☐ AS ☐

Cell Phone # : ( ) -

For Office Use Only: Application ID

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Section 2 - continued. HOUSEHOLD MEMBERS (List everyone who lives in this residence.)

Provide all requested information for all persons living in the house regardless of relationship whether or not you consider them a household member.

Use code values listed in the instructions at the beginning of Section 2 to complete Household Relationship, Hispanic Status, Race Status, Health Insurance Status, Highest Grade Completed and Employment Status.

Last Name: ☐ **Age:** ☐ **Household Relationship(see list above for values):** ☐

First Name: ☐ **Birth Date:** __ / __ / __ **Veteran (Y/N):** ☐ **Disabled(Y/N):** ☐

Mid Init: ☐ **SSN:** ___ - __ - ____ **Gender(M/F):** ☐ **In School(Y/N):** ☐ **In Literacy Training (Y/N):** ☐

Alias Last Name: ☐ **Hispanic Status:** ☐ **Highest Grade(see list above):** ☐

Alias First Name: ☐ **Employment (see list above):** ☐

Health Insurance (see list above): MA ☐ MC ☐ PV ☐ CH ☐ OT ☐ NN ☐ VA ☐ **Work Phone # :** ( ) -

Race (see list above): W ☐ B ☐ AI ☐ P ☐ AS ☐ **Cell Phone # :** ( ) -

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Last Name: ☐ **Age:** ☐ **Household Relationship(see list above for values):** ☐

First Name: ☐ **Birth Date:** __ / __ / __ **Veteran (Y/N):** ☐ **Disabled(Y/N):** ☐

Mid Init: ☐ **SSN:** ___ - __ - ____ **Gender(M/F):** ☐ **In School(Y/N):** ☐ **In Literacy Training (Y/N):** ☐

Alias Last Name: ☐ **Hispanic Status:** ☐ **Highest Grade(see list above):** ☐

Alias First Name: ☐ **Employment (see list above):** ☐

Health Insurance (see list above): MA ☐ MC ☐ PV ☐ CH ☐ OT ☐ NN ☐ VA ☐ **Work Phone # :** ( ) -

Race (see list above): W ☐ B ☐ AI ☐ P ☐ AS ☐ **Cell Phone # :** ( ) -

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Last Name: ☐ **Age:** ☐ **Household Relationship(see list above for values):** ☐

First Name: ☐ **Birth Date:** __ / __ / __ **Veteran (Y/N):** ☐ **Disabled(Y/N):** ☐

Mid Init: ☐ **SSN:** ___ - __ - ____ **Gender(M/F):** ☐ **In School(Y/N):** ☐ **In Literacy Training (Y/N):** ☐

Alias Last Name: ☐ **Hispanic Status:** ☐ **Highest Grade(see list above):** ☐

Alias First Name: ☐ **Employment (see list above):** ☐

Health Insurance (see list above): MA ☐ MC ☐ PV ☐ CH ☐ OT ☐ NN ☐ VA ☐ **Work Phone # :** ( ) -

Race (see list above): W ☐ B ☐ AI ☐ P ☐ AS ☐ **Cell Phone # :** ( ) -

For Office Use Only: Application ID

Section 2 - continued. HOUSEHOLD MEMBERS (List everyone who lives in this residence.)

Provide all requested information for all persons living in the house regardless of relationship whether or not you consider them a household member.
Use code values listed in the instructions at the beginning of Section 2 to complete Household Relationship, Hispanic Status, Race Status, Health Insurance Status, Highest Grade Completed and Employment Status.

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Age:** ☐☐☐ **Household Relationship(see list above for values):** ☐
First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **Birth Date:** ☐☐ / ☐☐ / ☐☐☐☐ **Veteran (Y/N):** ☐ **Disabled(Y/N):** ☐
Mid Init: ☐ **SSN:** ☐☐☐ - ☐☐ - ☐☐☐☐ **Gender(M/F):** ☐ **In School(Y/N):** ☐ **In Literacy Training (Y/N):** ☐
Alias Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Hispanic Status:** ☐ **Highest Grade(see list above):** ☐
Alias First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **Employment (see list above):** ☐
Health Insurance (see list above): MA ☐ MC ☐ PV ☐ CH ☐ OT ☐ NN ☐ VA ☐ **Work Phone # :** (☐☐☐) ☐☐☐ - ☐☐☐☐
Race (see list above): W ☐ B ☐ AI ☐ P ☐ AS ☐ **Cell Phone # :** (☐☐☐) ☐☐☐ - ☐☐☐☐

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Age:** ☐☐☐ **Household Relationship(see list above for values):** ☐
First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **Birth Date:** ☐☐ / ☐☐ / ☐☐☐☐ **Veteran (Y/N):** ☐ **Disabled(Y/N):** ☐
Mid Init: ☐ **SSN:** ☐☐☐ - ☐☐ - ☐☐☐☐ **Gender(M/F):** ☐ **In School(Y/N):** ☐ **In Literacy Training (Y/N):** ☐
Alias Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Hispanic Status:** ☐ **Highest Grade(see list above):** ☐
Alias First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **Employment (see list above):** ☐
Health Insurance (see list above): MA ☐ MC ☐ PV ☐ CH ☐ OT ☐ NN ☐ VA ☐ **Work Phone # :** (☐☐☐) ☐☐☐ - ☐☐☐☐
Race (see list above): W ☐ B ☐ AI ☐ P ☐ AS ☐ **Cell Phone # :** (☐☐☐) ☐☐☐ - ☐☐☐☐

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Age:** ☐☐☐ **Household Relationship(see list above for values):** ☐
First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **Birth Date:** ☐☐ / ☐☐ / ☐☐☐☐ **Veteran (Y/N):** ☐ **Disabled(Y/N):** ☐
Mid Init: ☐ **SSN:** ☐☐☐ - ☐☐ - ☐☐☐☐ **Gender(M/F):** ☐ **In School(Y/N):** ☐ **In Literacy Training (Y/N):** ☐
Alias Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Hispanic Status:** ☐ **Highest Grade(see list above):** ☐
Alias First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **Employment (see list above):** ☐
Health Insurance (see list above): MA ☐ MC ☐ PV ☐ CH ☐ OT ☐ NN ☐ VA ☐ **Work Phone # :** (☐☐☐) ☐☐☐ - ☐☐☐☐
Race (see list above): W ☐ B ☐ AI ☐ P ☐ AS ☐ **Cell Phone # :** (☐☐☐) ☐☐☐ - ☐☐☐☐

For Office Use Only: Application ID ☐☐☐☐☐☐☐☐☐

Section 2 - continued. HOUSEHOLD MEMBERS (List everyone who lives in this residence.)

Provide all requested information for all persons living in the house regardless of relationship whether or not you consider them a household member.
Use code values listed in the instructions at the beginning of Section 2 to complete Household Relationship, Hispanic Status, Race Status, Health Insurance Status, Highest Grade Completed and Employment Status. **Please attach sheet with additional household member information.**

Last Name: **Age:** **Household Relationship(see list above for values):**

First Name: **Birth Date:** / / **Veteran (Y/N):** **Disabled(Y/N):**

Mid Init: **SSN:** - - **Gender(M/F):** **In School(Y/N):** **In Literacy Training (Y/N):**

Alias Last Name: **Hispanic Status:** **Highest Grade(see list above):**

Alias First Name: **Employment (see list above):**

Health Insurance (see list above): MA ☐ MC ☐ PV ☐ CH ☐ OT ☐ NN ☐ VA ☐ **Work Phone # :** ( ) -

Race (see list above): W ☐ B ☐ AI ☐ P ☐ AS ☐ **Cell Phone # :** ( ) -

Section 3 HOUSING TYPE INFORMATION

Housing type: ***(Please check one.)***

- ☐ House - Modular (Single Family)
- ☐ Apartment or Duplex (Multi Family) - # Units in Building:
- ☐ Mobile Home
- ☐ Double-Wide Mobile Home

Year Dwelling was built

Number of bedrooms: ***(Please check one.)***

- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four or more

Rent or Own Home?

- ☐ Own Home
- ☐ Rent Home

Mobile Unit Rent Lot?

- ☐ Yes
- ☐ No

If you rent, provide name, address, and telephone number of your landlord:

Landlord Name: **Landlord Phone # :** ( ) -

Address Line 1: **City:**

Address Line 2: **State:** **Zip Code:**

* Do you receive governmental rent assistance? ☐ Yes ☐ No

* Does your rent include heating costs? ☐ Yes ☐ No

For Office Use Only: Application ID

Section 4 HOME ENERGY INFORMATION

A COPY OF YOUR MOST RECENT HEAT AND ELECTRIC BILL(S) SHOWING NAME, CURRENT ADDRESS AND ACCOUNT NUMBER(S) MUST BE ATTACHED. IF YOUR MAIN HEAT SOURCE IS OIL OR PROPANE AND YOU DO NOT HAVE THE BILL, OBTAIN A LETTER OF SERVICE FROM YOUR SUPPLIER. APPLICATIONS CAN ONLY BE MADE FOR THE DWELLING RESIDED IN AT THE TIME OF APPLICATION.

The primary (main) vendor is the vendor for the heat service you use the most:

Primary Vendor:

Account Number:

Home Energy Types used to heat a home are:
NG Natural Gas; **EL** Electricity; **PR** Propane; **WD** Wood; **CL** Coal; **OL** Fuel Oil

Home Energy Type(see list above for values):

The secondary vendor(s) are the vendor(s) for any alternate heat, electric or fuel, service you may use (may be same vendor as primary but different Energy Type):

Secondary Vendor:

Account Number:

Home Energy Type(see list above for values):

Secondary Vendor:

Account Number:

Home Energy Type(see list above for values):

Does your household currently receive or have you applied for assistance with heat/utility cost from another agency? ☐ Yes ☐ No

If yes, please specify where, when and provide verification of the assistance amount:

1. Does your furnace work? ☐ Yes ☐ No Comment:

2. Do you have Central Air Conditioning? ☐ Yes ☐ No

3. Do you have window/wall Air Conditioning (including an evaporative cooler)? ☐ Yes ☐ No

4. Has your household received a utility(energy) past due notice in the last 30 days? ☐ Yes ☐ No

5. Do you have less than 10% Deliverable Fuel(oil/propane/coal/wood) on hand? ☐ Yes ☐ No

6. Is your utility(energy) service currently disconnected? ☐ Yes ☐ No

7. Are you completely out of Deliverable Fuel (oil/propane/coal/wood)? ☐ Yes ☐ No

For Office Use Only: Application ID

Section 5 SOURCE OF INCOME

Please check ALL of the following sources of income that have been received by ALL MEMBERS OF YOUR HOUSEHOLD WITHIN THE PAST SIX (6) MONTHS.

- ☐ TANF (includes Tribal)
- ☐ SNAP / Food Stamps
- ☐ Supplemental Security Income (SSI)
- ☐ Veteran Administration
- ☐ General Assistance (includes Tribal)
- ☐ Social Security (SS or SSDI)
- ☐ Self Employment
- ☐ Salaried (Wages / Tips)
- ☐ Unemployment Insurance
- ☐ Interest Income
- ☐ Pension
- ☐ Property Income
- ☐ Alimony Payments
- ☐ Worker's Comp
- ☐ Educational Grants
- ☐ Loans
- ☐ Gifts (Money)
- ☐ Odd Jobs
- ☐ Tribal Income
- ☐ Utility Payments (Section 8 Housing)
- ☐ Child Support: If paid through MT CSED, provide case #'s
- ☐ Other: If checked, please explain in the following space: _____

Section 6 INCOME OF HOUSEHOLD MEMBERS

Enter the requested information for all household members regardless of age or relationship. Begin with last month and go back six (6) months. (Don't include SNAP/Food Stamps below). IF THERE IS ANY TIME PERIOD OF ZERO(0) INCOME, PLEASE EXPLAIN YOUR MEANS OF SURVIVAL.

COPIES OF DOCUMENTATION TO VERIFY ALL GROSS INCOME MUST BE INCLUDED

Month	Year	Sources and Amounts of Gross Income (Please specify each source of income and who received it.)	Total Gross Income for Month
EXAMPLE - JUNE	*2017*	*Joe-ABC Company $650; Jane-Social Security $500; Jane-Child Support $250*	*$1,400*

For Office Use Only: Application ID

Section 7 RESOURCES AND BUSINESS EQUITY

Please answer all questions for each of the resources listed below for all household members regardless of relationship. ***If the resource listed does not apply to your household, please print "None" under each section headed "FINANCIAL INSTITUTION". (You must provide verification of all resources, including full bank statement(s).)***

RESOURCES		FINANCIAL INSTITUTION / PHYSICAL ADDRESS / DATE	CURRENT BALANCE
Cash $	Checking Accounts $		
Savings Account(s)			$
Certificates of Deposit - Individual Retirement Accounts - Tax Sheltered Annuities - 401(K); 403(B) or any other retirement account			$
Cash value of stocks, bonds and other investments			$
Value of business assets, rental properties or property leases **(Self-employed households must provide this information).**			$
Physical address(es) and County of property/real estate other than the home in which you live and its adjoining land.			$
Physical address and County of the sale of primary residence (where you were living) and date sold.			$

Section 8 COLLEGE STATUS

Has any member of the household been enrolled at least half-time in a college or university in the last 12 months? ☐ Yes ☐ No

If yes, which household members? _____ _____ _____ _____

If yes, include a copy of all financial aid received. Which quarters or semesters did they attend? _____

If yes, was that person claimed last year as a dependent for Federal income tax purposes by someone in another household? ☐ Yes ☐ No

TRIBAL STATUS

Is any adult household member an enrolled tribal member? ☐ Yes ☐ No or direct descendant? ☐ Yes ☐ No

If yes, which household members? _____ _____ _____ _____ _____ _____

If yes, specify each person's tribal affiliation(s). _____ _____ _____ _____ _____ _____

Is your home located within the boundaries of a reservation? ☐ Yes ☐ No Is the household eligible for Tribal LIEAP benefits? ☐ Yes ☐ No

Is your home located on the Crow reservation? ☐ Yes ☐ No

Note: All adult household members who live on a reservation (other than the Crow Reservation), and who are Native American, enrolled tribal members or direct descendants should contact their Tribal LIEAP office for assistance. Native American household members who live on the Crow Reservation should contact District VII Human Resource Development Council (Billings) for assistance.

WEATHERIZATION

Do any household members have health conditions to take into consideration for weatherization of the residence? ☐ Yes ☐ No

If yes, which household members? _____ _____ _____ _____

If yes, list conditions. If you need additional space, please use a separate piece of paper. _____

For Office Use Only: Application ID

Section 9 AUTHORIZATION

PLEASE READ THE FOLLOWING AND SIGN AND DATE WHERE INDICATED.

This is an equal opportunity program. Discrimination is prohibited. I understand that this application is for Federal funds and that any falsification or concealment of a material fact may be prosecuted under Federal or State Laws. I understand the application must include information for all individuals living in the household including all gross income and resources.

I understand that homes are weatherized on a priority basis. If my home is prioritized this year, I authorize an agency representative to complete an energy audit of my home and install weatherization measures as determined to be necessary by the agency. **Refusal to allow weatherization measures to be applied to my home may result in suspension of Fuel Assistance benefits.** I have read; or have had read to me; all the above and all questions have been answered to my satisfaction. I also understand that Fuel Assistance benefits are computed for October 1 through April 30. I am responsible for any other costs not covered by Fuel Assistance benefits. I certify that the information provided herein is true, complete, and correct to the best of my knowledge. I also assign to the Department any rights to third party payments for emergency assistance services provided by the Department.

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO OBTAIN PERSONAL INFORMATION.

I authorize any individual, company, agency, or other entity which has information about me or my household, including, but not limited to, the information sources listed below to release or disclose information to the Montana Department of Public Health and Human Services (DPHHS) and/or to any agent or contractor to the DPHHS which is authorized to determine eligibility for Energy Assistance or Weatherization benefits. I authorize the disclosure of release of any information relevant to my eligibility for Energy Assistance or Weatherization benefits, including, but not limited to, the information to be released or disclosed listed below. I understand any information obtained will be kept confidential and will be used only for the purposes directly connected with the administration of benefits or services and only during the pertinent time period. I further understand that any information obtained may be released or disclosed to a proper government agency, court of law or law enforcement agency for purposes of legal investigative actions concerning fraud. I further understand that information contained on this application can be used in DPHHS electronic databases for the determination of eligibility for programs and/or to record services provided to my household for federal and /or state reporting purposes.

INFORMATION SOURCE: Banks, Savings & Loans, Credit Unions, Employers, Social Security Administration, Veterans Administration, State Department of Labor and Industry, Internal Revenue Service, State Department of Revenue, State Compensation Insurance Fund, Unemployment Compensation Division, County Clerk & Recorder, Bureau of Indian Affairs, Utility Suppliers and Vendors, Other Social Services Providers, Landlord, Child Support Enforcement Division, Office of Public Assistance, and other sources which may be deemed necessary.

INFORMATION TO BE RELEASED OR DISCLOSED: Banking Information, Certificates of Deposit, Stocks & Bonds, Safety Deposit Boxes (to be opened only in the presence of the client or his/her agent and representatives of the financial institution), Gross Earnings, Social Security Payments, V.A. Benefits, Personal and Business Income, Workers Compensation, Unemployment Compensation, Family Composition, Size of Home, Per Capita Payments, Lease Payments, Indian Income Maintenance (IIM) Accounts, Amount of Fuel Assistance received from agencies, Utility Account Information: including, but not limited to, Utility Account and Billing Information, Child Support Payments, Benefit Information.

Signature of head of household.

X_____ **Date:** _____ **SSN:** _____

Signature of all other household members age 16 or older.

X_____ **Date:** _____ **SSN:** _____

X_____ **Date:** _____ **SSN:** _____

X_____ **Date:** _____ **SSN:** _____

X_____ **Date:** _____ **SSN:** _____

For Office Use Only: Application ID

PLEASE FIND YOUR COUNTY BELOW AND RETURN YOUR APPLICATION TO THE APPROPRIATE OFFICE

Return application to:	<-- If you live in this county:	Return application to:	<-- If you live in this county:
Action for Eastern Montana 2030 North Merrill P.O. Box 1309 Glendive MT 59330-1309 377-3564/1-800-227-0703	CARTER CUSTER DANIELS DAWSON FALLON GARFIELD McCONE PHILLIPS POWER RIVER PRAIRIE RICHLAND ROOSEVELT ROSEBUD SHERIDAN TREASURE VALLEY WIBAUX	Rocky Mountain Development Council LIEAP Office 648 N. Jackson Street P.O. Box 1717 Helena MT 59624-1717 447-1625/1-800-356-6544	BROADWATER JEFFERSON LEWIS & CLARK
District IV HRDC 2229 5th Avenue Havre MT 59501 265-6743/1-800-640-6743	BLAINE HILL LIBERTY	District IX HRDC 32 South Tracy Avenue Bozeman MT 59715 587-4486/1-800-332-2796	GALLATIN MEAGHER PARK
Opportunities Incorporated 905 First Avenue North P.O. Box 2289 Great Falls MT 59403-2289 761-0310/1-800-326-0955	CASCADE CHOUTEAU GLACIER	Community Action Partnership of Northwest Montana 214 Main Street P.O. Box 8300 Kalispell MT 59904-1300 758-5433/1-800-344-5979	FLATHEAD LAKE LINCOLN SANDERS
North Central Area Agency on Aging 311 S. Virginia, Suite 2 Conrad MT 59425 271-7553/1-800-551-3191	PONDERA TETON TOOLE	District XI Human Resource Council 1801 South Higgins Avenue Missoula MT 59801 406-728-3710	MISSOULA MINERAL RAVALLI
District VI HRDC Centennial Plaza 300 First Avenue North, Room 203 Lewistown MT 59457 535-7488/1-800-766-3018	FERGUS GOLDEN VALLEY JUDITH BASIN MUSSELSHELL PETROLEUM WHEATLAND	Action Inc. 25 West Silver Street P.O. Box 3486 Butte MT 59702 533-6855/1-800-382-1325	BEAVERHEAD DEER LODGE GRANITE MADISON POWELL SILVER BOW
District VII HRDC 7 North 31st Street P.O. Box 2016 Billings MT 59103 247-4778/1-800-433-1411	BIG HORN CARBON STILLWATER SWEET GRASS YELLOWSTONE		

Legal Basis for Action:

MCA 53-2-201

ARM 37.70.101 ---------- 37.70.901

(PLEASE READ THE SECTION ON THIS NOTICE FOR YOUR FAIR HEARING RIGHTS AND REQUEST FORM).

IMPORTANT

REQUESTING A HEARING:

This form may be used to file a fair hearing if you feel your completed application has not been acted on in a timely manner or if you disagree with an adverse action taken on your case. You may file your request with your local Low Income Energy Assistance/ Weatherization Eligibility Office(L/WEO) or the Office of Fair Hearings.

FAIR HEARING STEPS:

1. Contact your local L/WEO for any assistance you feel you need in requesting a Fair Hearing.
2. Complete this form and mail this **entire document** to the: **Office of Fair Hearings**
   Box 202953
   Helena, Montana 59620-2953
3. You may be represented by an attorney or any other person of your choice or you may represent yourself. If you cannot afford an attorney, you may be able to receive representation from Montana Legal Services. Call, toll free, 1-800-666-6124.
4. The Office of Fair Hearings will direct your local L/WEO to schedule an informal Administrative Review to discuss your case. At that time you will be able to present your facts and any law you have to support your case, and the Department will do the same. The possibilities of settlement will be explored. You must then sign a form indicating the outcome of the Administrative Review which must be returned to the Officce of Fair Hearings.
5. If at any time, you wish to withdraw your request for a Fair Hearing, you may do so by sending a written and signed letter to the Office of Fair Hearings.
6. If your case was not resolved by the Administrative Review, then a Fair Hearing will be conducted by an impartial Hearings Officer appointed by the State of Montana. You will be mailed a certified letter notifying you of the date, time, and place of the hearing and other pertinent information.

DO NOT COMPLETE THIS UNLESS YOU WISH TO FILE A FAIR HEARING.

ENERGY ASSISTANCE REQUEST FOR FAIR HEARING

CLAIMANT'S NAME:	SOCIAL SECURITY NO:	PHONE:

STREET ADDRESS:	CITY:	ZIP CODE:

This is to request a fair hearing. I am making this request because: _____

_____

_____

I have an attorney: ☐ Yes ☐ No My attorney's name is: _____

His/her address is: _____ His/her phone number is: _____

If you are requesting a hearing because of a reduction or termination in benefits, please check one of the following:

( ) I want to continue receiving the benefits I now receive until the hearing. If I lose the hearing I will repay any excess benefits I receive.
( ) I do not want to continue receiving the benefits I now receive until the hearing. If I win the hearing I will be restored any benefits I lost.

Complete this form and mail the **entire document** , to the **Office of Fair Hearings, Box 202953, Helena, Montana 59620-2953,** or submit it to your local L/WEO. If you wish, please keep a copy for your records.

_____ _____ _____

(Claimant or Authorized Representative) (Phone) (Date)

HOMEOWNER/RENTER INCOME TAX CREDIT (FORM 2EC)

Montana homeowners or renters age 62 or older may qualify for this program and receive up to a $1,000 refundable tax credit, even if you do not have to file an income tax return.

Eligibility of this program is based on your age, residency, income of all the household members and the amount you pay in rent or property taxes. Total household income must be less than $45,000. You may be able to claim refunds for previous years.

Form 2EC

If you have any questions filling out the Form 2EC, please contact us at (406) 444-6900.

Clear Form

File online at *revenue.mt.gov*

2017 Montana Elderly Homeowner/Renter Credit

File alone or with your Form 2. You can file electronically for free at *revenue.mt.gov*.

Form 2EC

Mark this box if this is an **amended form**.

First Name and Initial	Last Name	Social Security Number	Deceased? Date of Death
			M M D D 2 0 Y Y

Spouse's First Name and Initial	Last Name	Spouse's Social Security Number	Deceased? Date of Death
			M M D D 2 0 Y Y

Mailing Address	City	State	Zip+4

Part I - Qualifications (You must answer "Yes" to each of the following four statements to qualify for this credit.)

I was age 62 or older as of December 31, 2017	Yes	No
I occupied a Montana residence as an owner or renter for a total of six months or more during 2017	Yes	No
I resided in Montana for nine months or more during 2017	Yes	No
My gross household income was less than $45,000 in 2017 (see instructions)	Yes	No

Part II - Net Household Income

1.	Enter your total gross household income (see worksheet on page 2EC-2 of the instructions)	1.	00
2.	Your standard exclusion is entered here for you	2.	6300 00
3.	Subtract line 2 from line 1 and enter the result here, but not less than zero	3.	00
4.	Enter your multiplier rate from the Household Income Reduction Table on page 2EC-2 of the instructions	4.	.
5.	Multiply line 3 by line 4 and enter the result here. **This is your net household income.**	5.	00

Part III - Credit Computation. Enter physical address of Montana residence (if different than mailing address) in the boxes below.

Address	City

6.	Enter the property tax that you were billed for your Montana residence and up to one acre in 2017	6.	00
7.	Enter the rent that you paid in 2017 for your Montana residence	7.	00
8.	Multiply line 7 by 0.15 (15%) and enter the result	8.	00
9.	Add lines 6 and 8; enter the result	9.	00
10.	Subtract line 5 from line 9 and enter the result, but not less than zero	10.	00
11.	Enter the lesser of line 10 or $1,000	11.	00
12.	Enter the percentage from the Credit Multiplier Table on page 2EC-3 of the instructions that corresponds to your gross household income reported on line 1	12.	.
13.	Multiply line 11 by the percentage reported on line 12. **This is your elderly homeowner/renter credit.** ▶	13.	00

- If filing Form 2, enter the amount from line 13 above on Schedule V, line 24. Include Form 2EC with Form 2.
- If not required to file Montana Form 2, mail Form 2EC or file it online for free at *revenue.mt.gov*.

Mail your completed Form 2EC to:
Montana Department of Revenue
PO Box 6577
Helena, MT 59604-6577

Direct Deposit Your Refund
Complete 1, 2, 3 and 4. See instructions on page 2EC-3.

1. RTN# 2. ACCT#

3. If using direct deposit, you must mark one box. ☐ Checking ☐ Savings

4. Is this refund going to an account that is located outside of the United States or its territories? ☐ Yes ☐ No

Questions? Call us at (406) 444-6900 or TDD (406) 444-2830 for hearing impaired.

Under penalties of false swearing, I declare that I have examined this claim, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct and complete.

Your Signature is Required	Date	Daytime Telephone Number	**Spouse's Signature**	Date
X			X	

Paid Preparer's Signature	Paid Preparer's PTIN/SSN	Firm's FEIN	*For Department Use Only*

Third Party Designee	Third Party Designee's Printed Name
Do you want to allow another person (such as a paid preparer) to discuss this return with us (see page 2EC-3)? ☐ Yes ☐ No	Third Party Designee's Phone Number

17CA0101

Instructions for Elderly Homeowner/Renter Credit Form 2EC

The Montana Elderly Homeowner/Renter Credit is a property tax relief program that provides a refundable tax credit of up to $1,000. To claim this credit, you must live in a household where the total income of **all household members** is less than $45,000 for that year, be 62 or older, have lived in Montana for more than nine months during the tax year, and occupied a Montana residence as a renter, owner or lessee for a total of six months or more during the year.

The total amount of income from all household members used to determine your eligibility is called "gross household income." Gross household income does not always equal the taxable income that individuals report on their Montana income tax return. It also includes income that is normally not taxable. Part II of these instructions provides a list of the income that must be included in gross household income.

You can claim this credit directly on this return if you are not required to file a Montana individual income tax return (Form 2). If you are required to file Form 2, you must provide names, addresses and social security numbers on the Form 2EC that you include with Form 2.

If either spouse died during the claim year, enter the date of death in the appropriate box. If filing an individual tax return is not required and this claim is for either a deceased individual or a married couple who are both deceased, please include federal Form 1310.

Part I – Qualifications

You need to answer "Yes" to all four statements before you apply. Any "No" answer means you are not eligible for the credit.

Even though you may be eligible for the credit after completing Parts II and III of this form, you still may not be entitled to receive any credit. Note that only one claim is allowed per household and that married taxpayers who are living apart may qualify for only one credit per year.

Age 62 Test. If you were 62 or older as of December 31, 2017, you can answer "Yes" to this statement. If you are married and both spouses own or rent your residence, only one of you has to meet the age requirement.

Six-Month Test. You can answer "Yes" to this question as long as you have occupied one or more residences as an owner and/or renter for six months or more during the year.

Nine-Month Test. You must have lived in Montana for nine months or more during the year to answer "Yes." If you are the personal representative of the estate of an eligible individual who died during the year, you cannot claim this credit if that individual died before October 1, 2017. If you are married filing this claim with your spouse and if your spouse, who would have been the only eligible individual, dies before October 1, 2017, you are not eligible for this credit. You are eligible only if, as a surviving spouse, you are age 62 or older and you can continue to answer "Yes" to the other statements.

Gross Household Income. If your gross household income was less than $45,000, you can answer "Yes." Your gross household income includes all income received by all individuals in the household. Use the worksheet on page 2EC-2 to calculate your Gross Household Income.

Part II – Net Household Income

Enter your gross household income on line 1. This is all the income received, taxable and nontaxable, by all individuals who live in your household. This includes, but is not limited to, the income of adult children and unrelated individuals living in your household. In addition to federal adjusted gross income, the following are examples of items that **are included** in gross household income:

- Pension and annuity income (this includes railroad retirement)
- Disability benefits including, but not limited to, veteran's disability, SSI payments and workers' compensation
- Any capital gains that you excluded from your Montana adjusted gross income, such as the gain from the sale of your primary residence
- Alimony and support payments
- Nontaxable strike benefits
- Cash, public assistance and relief - Do not include LIEAP (Low Income Energy Assistance Program) or SNAP (Supplemental Nutrition Assistance Program, formerly known as the Food Stamp Program)
- Interest on federal, state, county and municipal bonds
- All social security payments except those paid directly to a nursing home
- Elderly homeowner/renter credit allowed or other federal or state refundable credits
- Long term care insurance benefits

You may have a basis (the amount you invested) in some items above. If applicable, you may reduce the amount received as an item of income by your basis in that item. For example, if you paid $50,000 for the ownership of a primary residence, $50,000 is your basis. If you sell that residence for $80,000, your gross household income only includes the gain of $30,000 ($80,000 sales price minus $50,000 basis).

If you received pension or annuity income or a distribution from a traditional IRA, include the federally taxable amount as shown on your Form 1099.

Do not reduce your gross household income by any losses that you included in your federal adjusted gross income.

The following Gross Household Income Worksheet can be used to help you calculate your gross household income.

Gross Household Income Worksheet		
Income Source (taxable and nontaxable)		Amount
1.	Wages, salaries, bonuses, tips, etc.	
2.	Business, partnership, rent, royalties (do not include losses).	
3.	Dividends, interest (including interest from federal, state, county and municipal bonds) and capital gains (do not include capital losses).	
4.	Any federal or state refundable credits including the 2EC credit.	
5.	Alimony, cash public assistance, unemployment.	
6.	Pension, annuities, IRA distributions, benefits from railroad retirement, public employee's retirement, veteran's disability and social security (do not include social security income paid directly to a nursing home).	
7.	Income from any source or other household members not included above	
8.	Add lines 1 through 7; enter the total here and on Form 2EC, line 1. This is your gross household income.	

Line 4 – Household Income Reduction Table

If your household income on line 3 is:		
At least	But not more than	Your multiplier is
$0	$1,999	0.000
$2,000	$2,999	0.006
$3,000	$3,999	0.016
$4,000	$4,999	0.024
$5,000	$5,999	0.028
$6,000	$6,999	0.032
$7,000	$7,999	0.035
$8,000	$8,999	0.039
$9,000	$9,999	0.042
$10,000	$10,999	0.045
$11,000	$11,999	0.048
$12,000 and greater		0.050

Part III – Credit Computation

Enter the physical address of the residence you are basing your claim on if it is different than the mailing address shown on this form or your Form 2. If you had multiple residences during the year, enter the address of the one you occupied the longest. You need to include a copy of your 2017 property tax bill and/or your signed rent receipts when you file Form 2EC. If you are unable to get signed rent receipts, a statement detailing the rent paid during the year signed by your landlord is an acceptable substitute. If you are filing electronically, you do not need to send us your property tax bill or rent receipts. When you file electronically, you represent that you have completed Form 2EC, retained the required documents in your tax records and will provide those documents to us upon request.

Line 6 – Property Tax Billed

Report the amount of taxes, special assessment and fees that were billed on the property tax statement. Do not report the amount of property tax you actually paid.

You are allowed only the property tax billed on your primary residence and up to one acre of land that is associated with this residence. If the one-acre farmstead or primary acre is not separately identified on your tax bill and if your ownership is less than 20 acres, your property tax to be used in the credit calculation is the larger of: total amount of property tax billed multiplied by 80%, or total amount of property tax billed divided by the total acreage.

If your property tax bill is on property that you held in a revocable trust and if you are the grantor(s) and trustee(s) of that property, you can qualify for this credit. If your property taxes are billed to your living trust or life estate, you can qualify for this credit. If the property occupied by you is in a name other than your own, the property taxes billed for that property can qualify as rent only.

Line 7 – Rent Equivalent Paid

Your rent is only the amount of money that you paid to occupy your home. If you live in a health care, long-term care, personal care or residential care facility, the rent allowed is the actual out-of-pocket rent that you paid, excluding services provided by staff, that is board expenses such as meals, housekeeping, transportation and medical or paramedical expenses such as nursing care, assisted living care and memory care. The out-of-pocket rent can be determined using a facility statement providing the breakdown between rent and these amenities, or by deducting from your total payments some proportional amount representing board and/or care as follows.

1.	Total payment to the facility	
2.	Multiply 1 by 20% if you received board services on a continuous basis (meal, housekeeping, laundry, transportation, entertainment)	
3.	Multiply line 1 by 30% if you received care on a continuous basis (nursing care, assisted living care, memory care)	
4.	Out-of-Pocket Rent, deduct lines 2 and 3 from line 1	

If you wish to claim the credit for a previous tax year still open and you were living in a long term care facility, you must use the rules that applied during these years. Refer to the instructions of each tax year.

Do not use rent you pay for an apartment or a facility that is exempt from property tax because the credit is not allowed in these situations. Verify with your landlord or facility that the property is subject to property taxes beyond assessments such as sewer and garbage fees. You may also contact us for assistance in determining if the property is exempt from property tax. Items that also should not be included as rent equivalent paid on line 7 are as follows (this list is not all inclusive):

- Mortgage payments, including mortgage interests
- Nursing home costs that are paid directly from social security to the facility
- Rent paid for you by a rental assistance program (this amount should also not be included in your gross household income)

Line 12 – Credit Multiplier Table

If the amount on line 1 is:	Enter this figure on line 12:
Less than $35,000	1.00 (100%)
$35,000 to $37,500	0.40 (40%)
$37,501 to $40,000	0.30 (30%)
$40,001 to $42,500	0.20 (20%)
$42,501 to $44,999	0.10 (10%)
$45,000 and greater	0.00 (0%)

Sign and File your Return

Direct Deposit

If you would like to use direct deposit, enter your financial institution's routing number (RTN#) and your account number (ACCT#) in the space provided. Your routing number will be nine digits and your account can be up to 17 characters, including numbers and letters. Mark whether your account is a checking or savings account and if your refund will go to a bank outside of the United States and its territories.

If your financial institution does not accept the direct deposit or if the direct deposit information that you provided is incomplete, we will mail you a refund check.

Sign Your Credit Claim

This form is not considered a valid claim unless you sign it. If you are filing a joint claim, your spouse must also sign. If you have someone prepare your Form 2EC, you are still responsible for the correctness of the claim.

Electronic Signatures

If you are filing your claim electronically, you are not required to actually sign your claim. The act of filing your claim electronically signifies your declaration, under the penalty of false swearing, that you are the taxpayer identified in the claim and that the information in the claim is true, correct and complete.

Filing electronically, with this declaration, is your signature.

Daytime Phone Number

Providing your daytime phone number may help speed the processing of your claim. We may have questions about items on this form. Your answer may allow processing your claim without mailing you a letter. If you are filing a joint claim, you can enter either your or your spouse's daytime phone number.

Paid Preparer

Anyone you pay to prepare your claim must sign it and include his or her Preparer Tax Identification Number (PTIN) in the space provided. Preparers should have a PTIN, but the preparer's Social Security Number (SSN) may be used when the paid preparer does not have a PTIN. The paid preparer must also include his or her firm's Federal Employer Identification Number (FEIN), if applicable. The preparer must give you a copy of this form for your records. Someone who prepares your claim but does not charge you should not sign your claim.

Third Party Designee

If you want to allow your preparer, a friend, a family member or any other person you choose to discuss your 2017 Form 2EC with the department, mark the "Yes" box in the bottom of the signature block. You must also enter the designee's printed name and phone number. If you do not complete this section in its entirety, we cannot discuss your claim with a third party.

If you mark the "Yes" box, you, and your spouse if filing a joint claim, are authorizing the department to call the designee to answer any questions that may come up during the processing of your claim. You are also authorizing the designee to:

- Give the department any information that is missing from your claim;
- Call the department for information about the processing of your claim or the status of your refund;
- Receive copies of notices or transcripts related to your claim, upon request; and
- Respond to notices from the department about math errors, offsets and claim preparation.

You are not authorizing the designee to discuss any other tax year, receive any refund check, bind you to anything or otherwise represent you before the department. If you want to expand the designee's authorization, please view information about granting someone power of attorney at *revenue.mt.gov*.

The authorization automatically ends no later than the due date (without regard to extensions) for filing your 2018 return. This is April 15, 2019, for most people.

File Your Form 2EC

File Form 2EC with your Form 2, or alone if you are not required to file a Montana tax return, through our website. For further information on filing Form 2EC electronically, visit our website at *revenue.mt.gov*.

If you choose not to file electronically and you are not required to file Montana Form 2, mail your Form 2EC to:

Montana Department of Revenue
PO Box 6577
Helena, MT 59604-6577

How can I find out more about this credit or other tax matters, such as property tax relief?

Call us at (406) 444-6900 or visit our website at *revenue.mt.gov*.

Montana Department of REVENUE

CLEAR FORM

ASSESSMENT CODE:

Property Tax Assistance Program (PTAP) Application for Tax Year 2018

15-6-305, MCA

Part I. General Information

- Apply by April 15.
- You have to meet income and property ownership/occupancy requirements every year.
- The benefit only applies to the first $200,000 of value of your primary residence. For agricultural and timber parcels, the only eligible land is the one-acre home site.
- Once you have applied for the program, we will notify you each year whether you qualify. You will be included in the program's annual income verification until you move from your residence.

Part II. Required Information

Property Owner Name

_____

Birth Date_____ ❑ Male ❑ Female

Social Security Number _____ - ____ - _____

Contact Phone Number_____

Spouse's Name

_____

Birth Date_____ ❑ Male ❑ Female

Social Security Number _____ - ____ - _____

Contact Phone Number_____

County _____

Applicant's Mailing Address

_____

_____

Applicant's Primary Residence Physical Address

_____

_____

Did you file a Montana income tax return for tax year **2016**? ..... ❑ Yes ❑ No

Provide your **2016** Federal Adjusted Gross Income (FAGI), excluding capital and income losses. Include your spouse's income if you are married. (Spouses' incomes are included regardless if they are owners of the property.). ..... $_____
If you are new to Montana, provide a copy of your **2016** federal income tax return.

Is your only income from social security, veterans' benefits and/or other nontaxable sources? ..... ❑ Yes ❑ No
If yes, include a copy of your social security statement and/or other income documentation with this completed application form.

If this application is for a mobile or manufactured home, do you own the land upon which your home is located? ..... ❑ Yes ❑ No

Return your completed and signed application to your local Department of Revenue office. Your application must be postmarked or hand delivered by April 15. Go to *revenue.mt.gov* and click on *Property Assessment*, then *Contact Us* for the mailing addresses of our 56 local county Department of Revenue offices or call us at (406) 444-6900 or Telephone Device for the Deaf - TDD at (406) 444-2830. (If you miss the deadline, apply as soon as possible to ensure you are included in the program's verification process for the following tax year.)

Important! Your signature is required in Part IV.

Part III. Qualifying Criteria

You must own or currently be under contract to purchase your home or mobile/manufactured home and live in the home as your primary residence for at least seven months of the year.

For tax year 2018, the income guidelines are:

- A single applicant's Federal Adjusted Gross Income (FAGI), excluding capital and income losses, must be less than $21,607.
- Head of household and married applicants' FAGI must be less than $28,810.
- Spouses' incomes are included regardless of whether they are owners of the property.

You only need to report your income one time. In future years, we will determine your eligibility through our annual verification process.

Part IV. Affirmation and Signature(s)

Under penalty of law, I/we affirm that I/we are owners of the property on which we are applying for the property tax benefit, that I/we occupied the property as my/our primary residence for at least seven months of a calendar year and that the information provided in this application form is true and correct.

X Property Owner Signature _____ Date _____

X Property Owner's Spouse Signature _____ Date _____

X Signature of Person Completing this Form
(if other than applicant)_____ Date_____

Printed Name_____ Phone _____

Relationship to Applicant _____Email or Other Contact Information_____

Please let us know how you heard about the Property Tax Assistance Program (PTAP).

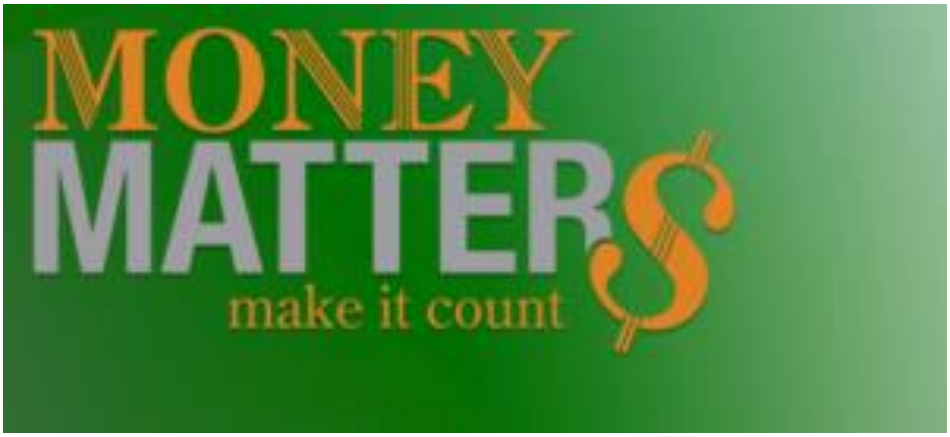
_____

_____

Questions? Please call us at (406) 444-6900 or Telephone Device for the Deaf - TDD at (406) 444-2830, or visit our website at *revenue.mt.gov*.

2018 Income Guidelines for the Property Tax Assistance Program		
Single Person	**Married or Filing Head of Household**	**Percent Reduction**
$0 - 8,643	$0 - $11,524	80%
$8,644 - $13,253	$11,525 - $20,167	50%
$13,254 - $21,607	$20,168 - $28,810	30%

Financial Skill Building Workshop



The goal of Financial Skill Building Workshop is to provide support to help strengthen and improve an individual's and family's financial knowledge and decision-making skills to achieve financial freedom. This is a great program for anyone looking to become more educated about personal financial management. The class is taught by certified financial counselors and other professionals from the community on a range of topics including:

- Creating a Spending Plan that works
- Saving for future goals
- Evaluating your credit, rebuilding credit and using credit wisely
- Avoiding pitfalls and consumer traps

Registration: Click here for the registration form. If you have any questions please call (406) 758-5420 or email kbullock@capnwmt.org
Workshop Fee: Financial Skill Building Workshops are FREE, but advanced registration is **REQUIRED**.
Counseling: One on One counseling is free and specific to your situation. Please let the workshop leader know if you want a private appointment. Or, if you are not attending the workshop, please call (406) 758-5420 to make an appointment.
Location: Community Action Partnership of NW MT (CAPNM), 214 Main St, Kalispell, MT 59901
If you have special needs such as those covered by the Americans with Disabilities Act please let us know and we can make accommodations for you.

Note: Childcare and dinner provided for evening workshops.
Questions: Contact 406-758-5420

FINANCIAL ASSISTANCE POLICY

PURPOSE

The Mission of Kalispell Regional Healthcare is to improve health, comfort, and life. The KRH Core Values are to: uphold Integrity in our words and actions; show Compassion to every person, every time; provide Service to our patients, our co-workers, and our community; demonstrate Excellence every day, in every way; and take Ownership for all we do. In carrying out our Mission and acting on our Core Values, we provide healthcare services to all persons in need, without regard to whether the patient is personally able to pay fully for the care received.

For the purposes of this Policy, Kalispell Regional Healthcare includes its hospitals Kalispell Regional Medical Center ("KRMC") and The HealthCenter ("THC"); and Northwest Orthopedics and Sports Medicine ("NOSM"), as well as their employed physicians and other healthcare services providers. KRMC, THC, NOSM, and their employed physicians and other healthcare services providers are called the "KRH Providers" in this Policy. Also, the term "KRH" includes Kalispell Regional Healthcare and the KRH Providers, unless stated otherwise.

Some KRH patients will not have the financial means to pay fully the charges made for the care provided to them by the KRH Providers and other healthcare services facilities or providers. This may be the case even when a portion of the bill for those charges is paid for by a governmental healthcare program, like Medicare and Medicaid, or a healthcare benefits plan or insurance. For that reason, KRH provides financial assistance to its patients for Emergency Care and Medically Necessary Care through a discount/reduction to the portion of the billed amount that the patient is personally responsible to pay, which is called the "Self-Pay Balance" in this Policy. In order to provide guidance to KRH patients, their caregivers, the public, and KRH staff about the KRH financial assistance program, KRH has adopted this Policy and related procedures. The Policy and related procedures are intended to meet the requirements of Internal Revenue Code section 501(r) (called "section 501(r)" in this Policy.

Defined terms used in this Policy, normally those words with initial capital letters, have important meanings. The definitions of these terms appear in the Definition of Terms section of this Policy below.

FINANCIAL ASSISTANCE POLICY

The KRH Providers will provide a reasonable amount of financial assistance to eligible patients for the cost of Emergency Care and Medically Necessary Care provided by the KRH Providers. KRH is committed to providing this financial assistance to its patients who are unable to pay the Self-Pay Balance based on their individual financial situations. The determination of whether a patient is eligible for, and the amount of financial assistance to be given, will be made at the time the service is performed or hospital discharge or as soon thereafter as possible, in accordance with the provisions of this Policy.

This Policy applies to all of the KRH Providers. Eligibility for and the amount of financial assistance provided by KRH under this Policy may also be accepted and applied by other healthcare services providers who deliver Emergency Care and Medically Necessary Care in KRMC or THC. A list of the other healthcare services providers and whether they follow, or do not follow, the KRH financial assistance policy when they perform a service related to an Emergency Care or Medically Necessary Care in KRMC or THC, is available on the KRH website and in writing. Patients seeking a discount for services provided by a non-KRH Provider who has not joined in this Policy need to contact that other healthcare services provider directly and work with that provider to see what, if any, financial assistance is available from that provider, and if so, the process for applying for its financial assistance.

This Policy has been adopted by the Board of Trustees of Kalispell Regional Healthcare System and the Board of Managers of NOSM.

All charges for Emergency Care and other Medically Necessary Care performed by the KRH Providers are eligible for financial assistance consideration. Services other than Emergency Care and Medically Necessary Care, such as cosmetic services, are not covered by this Policy.

Patients need to understand that financial assistance is not a substitute for personal responsibility. Patients are expected to cooperate fully with KRH procedures for obtaining financial assistance and to contribute to the cost of their care based on their ability to pay. Individuals and/or families with the financial capacity to purchase health insurance or who qualify for government health care programs are encouraged to get that coverage, as a means of assuring access to health care services and aiding in the payment for their health care.

Any patient, as well as the patient's Responsible Party (such as the parents of a patient who is a minor child), can submit an application for financial assistance. Financial assistance can include full or partial discount to a Self-Pay Balance, as well as assistance in enrolling in government health plans like Medicaid, and referral to other state and county assistance programs. It is the responsibility of the patient to specify the particular healthcare services accounts that are to be included in the determination of eligibility for and amount of financial assistance. KRH does not assume this responsibility.

A copy of a summary of this Policy, as well as information and assistance about how the Policy may apply to a particular patient's situation may be obtained, (1) in person at a check-in desk in the hospital or a KRH Providers clinic, (2) by contacting a Patient Business Services Representative at 1-406-756-4408 (an automated line), (3) by mailing a request to: Patient Business Services, 310 Sunnyview Lane, Kalispell, MT 59901, or (4) by coming to the Patient Business Services office at 160 Heritage Way (the Two Medicine building), Kalispell, between 8A.M. and 4:30 P.M. on week days, or by speaking with the Patient Billing Advocate located in the Kalispell Regional Medical Center facility off the main lobby, at 310 Sunnyview Lane, Kalispell, MT 59901 .

HOW TO APPLY FOR FINANCIAL ASSISTANCE

A patient applies for financial assistance by completing a Financial Assistance Application and supplying the requested information and documentation. The information and documentation submitted is subject to verification. An application for financial assistance should be made as soon as possible, preferably in advance of receiving healthcare services. The Application Period will normally end on the two hundred fortieth (240th) day after the first post-hospital discharge, or other post-service, billing statement is sent to the patient. There are a few exceptions to the time that the application period will end that are dealt with specifically in this Policy.

Applying for financial assistance can be initiated by requesting a Financial Assistance Application, as well as obtaining additional information and assistance, (1) in person at a check-in desk in the hospital or a KRH Providers clinic, or (2) over the phone by calling 1-406-756-4408 (an automated line), or (3) through the mail, or (4) off the KRH website (www.kalispellregional.org/krmc/) under the tab "Financial Assistance". Completed applications need to be sent to Patient Business Services, 310 Sunnyview Lane, Kalispell, MT 59901, Attn: Financial Assistance Application.

HOW IS ELIGIBILITY FOR FINANCIAL ASSISTANCE DETERMINED?

KRH uses the general Federal Poverty Guidelines as the primary ability to pay measurement tool to determine eligibility for financial assistance. The current Federal Income Poverty level amounts may be found online at: https://www.healthcare.gov/glossary/federal-poverty-level-FPL/. Other circumstances may also be taken into account in making the final determination.

Following receipt of a Financial Assistance Application, a Patient Business Services Representative reviews it for completeness. If it is complete, the patient will be notified of that. A decision on eligibility for financial assistance and, if so, the amount of financial assistance will be made and the patient notified promptly. If the application is not complete, the Patient Account Representative will contact the patient with a written notice requesting the missing information or additional verifications and specify where that information or verifications are to be sent and who to contact if assistance is needed. The additional information or verifications should be returned within thirty (30) days, even if that thirty (30) day period ends after the original application period. If it is received within the thirty (30) day period and the original application period has expired, the application will still be reviewed and the patient informed whether the patient is eligible for financial assistance and, if so, the amount of financial assistance. If the thirty (30) day period is not beyond the end of the two hundred forty (240) day application period, as long as you submit the needed information or verifications before the end of the application period, it will be accepted.

A patient qualifies for financial assistance if the patient's Family Income is less than 400% of the Federal Poverty Guidelines.

Upon receiving a complete Financial Assistance Application, if the Patient Business Services Representative believes the patient may qualify for Medicaid, KRH will postpone making a decision on financial assistance until after the patient's Medicaid application has been completed and submitted and a determination as to the patient's Medicaid eligibility has been made. The Patient Services Representative will arrange for assistance for the patient in determining eligibility and in making the application for Medicaid, if requested by the patient.

HOW IS THE AMOUNT OF FINANCIAL ASSISTANCE DETERMINED?

Once the amount of financial assistance for a patient is determined using the following general guidelines, information and factors:

A. If a patient's Family Income is less than 200% of the Federal Poverty Guidelines, the patient is eligible for a 100% write off of up to amount of the Self-Pay Balance.
B. If the patient's Family Income is more than 200% but less than 400% of the Federal Poverty Guidelines, the patient is eligible for a partial discount of the Self-Pay Balance, using a sliding scale (see the attached schedule). The sliding scale will be revised annually as the Federal Poverty Guidelines are updated.
C. A patient's Self-Pay Balance will never exceed twenty percent (20%) of the patient's Family Income. In cases when there is a Self-Pay Balance remaining after financial assistance is applied that exceeds the 20% limitation, the financial assistance will be adjusted to reflect the twenty percent (20%) limitation of the Patient's Family Income.
D. After these steps have been taken, if a patient is responsible for the Self-Pay Balance, the Patient Business Services Representative will work with the patient to establish appropriate payment arrangements.
E. A patient may also be eligible for a Prompt Payment Discount, which is set out under the heading "PROMPT PAY DISCOUNTS FOR A PATIENT'S SELF-PAY BALANCE" below.
F. The amount of third-party financial resources (including health insurance and health plan benefit coverage, or government health plan coverage [such as Medicare or Medicaid]), any recovery from a personal injury claim, Victims of Crime assistance, and non-hospital financial aid programs (including public assistance and private charity or foundation grant programs, for example).
G. The income and the value of Family Assets from all sources of the patient's household. This includes compensation from employment and other income.
H. Employment status: both past and future earnings potential is reviewed, to differentiate between temporary financial circumstances and those that are not likely to change soon.
I. All self-employed patients applying for financial assistance (whether as sole proprietor, partner of a

partnership, shareholder of a corporation, member of a limited liability company, etc.) must provide tax returns for that business that include all return schedules to support line item entries. KRH will add back to deductions taken from income for the following:

i. Depreciation expense
ii. Mileage
iii. Travel and entertainment

A Balance Sheet, Cash Flow, and Profit and Loss statement for the past two (2) years will also be required. If the business has been in existence for less than two (2) years, statements for the period of existence must be provided. Business assets such as vehicles and owned real and personal property, are also considered as Family Assets based on the patient's or Responsible Party's personal control of those assets.

If the patient does not have the documents referred to above, the patient may contact a Patient Business Services Representative to discuss whether other evidence may be provided to demonstrate eligibility.

J. Falsification of financial information (including number of dependents) or refusal to cooperate may result in a denial of financial assistance.
K. KRH reserves the right to change a financial assistance determination amount if financial circumstances have changed.

NOTIFICATION OF ELIGIBILITY AND THE AMOUNT OF FINANCIAL ASSISTANCE

The decision on eligibility for, and any amount of, financial assistance will be communicated to the patient in writing and documented in the Patient Business Services files. If the patient is eligible for financial assistance in an amount less than the full amount of the patient's Self-Pay Balance, the financial assistance notice will set out both the amount of financial assistance awarded and the remaining amount the patient owes for the care. The notice will also contain information about whom to contact to make payment arrangements, whether the patient may still take advantage of the prompt pay discount, how to obtain information about the AGB (amounts generally billed) computation, and, if a refund is due the patient because of amounts already paid, payment of the refund amount (unless that amount is less than Five Dollars ($5.00)).

A patient who can afford to pay a portion of the Self-Pay Balance is expected to do so. Payment arrangements may be made on the remaining Self-Pay Balance by contacting a Patient Business Services Representative.

If the patient/Responsible Party does not pay the amount agreed to in the payment arrangement, the account may be placed with a collection agency for collection in accordance with the KRH Collections Policy. This Financial Assistance Policy will be applied in tandem with the KRH Collections Policy. A copy of the KRH Collections Policy may be obtained by requesting it in person, over the phone by calling 1-406- 756-4408 (an automated line), through the mail, or from the KRH website (www.kalispellregional.org/krmc/) under the tab "Financial Assistance". Requests by mail need to be sent to Patient Business Services, 310 Sunnyview Lane, Kalispell, MT 59901.

Patient Business Services will retain all records relating to applications for and amounts of financial assistance provided to a patient for seven (7) years.

DURATION OF ELIGIBILTY FOR FINANCIAL ASSISTANCE

A determination of eligibility for financial assistance, and the amount of financial assistance determined, will remain valid for one (1) year. It will apply to the accounts for services for which the patient made application for financial assistance, and to accounts for services performed during that one (1) year period if also requested by the patient, unless the financial circumstances of the patient have changed. All patients must reapply for financial assistance after that one (1) year period

is over.

IDENTIFICATION OF PATIENTS WHO MAY QUALIFY FOR FINANCIAL ASSISTANCE, BUT WHO HAVE NOT SUBMITTED A FINANCIAL APPLICATION.

In order to identify patients who may be eligible for financial assistance but who may not have applied, KRH uses an income and health care credit scoring technology. KRMC uses the following process to identify these additional potential financial assistance cases, called presumptive eligibility for financial assistance:

A. KRMC performs a review of outstanding balances for patients through a computerized process to determine a patient's potential for financial assistance.
B. The indicators used in this process include information from outside sources that provide KRH guidance in assessing the patient's Family Income and household size. The possible eligibility under this presumptive eligibility method for financial assistance will be used only for patients whose Family Income appears to be four hundred percent (400%) or less of the Federal Poverty Limits.
C. If the indicators show that the patient may be eligible for financial assistance at less than the most generous financial assistance provided by KRH, KRH will notify the patient of the basis on which the presumptive eligibility was determined and the way to apply for more generous financial assistance. The patient will be given (90) days to complete and submit an application to determine if the patient is eligible for more generous assistance. If the patient submits a complete application during that period of time, the process for determining financial assistance following the submission of a complete application will be followed.
D. Patients who are identified as eligible for presumptive financial assistance will receive three (3) monthly billing statements, over roughly a ninety (90) day period. If the patient has not filed a completed financial assistance application ,after these three (3) billing statements have been sent since the first post-hospital discharge (or other post-service) billing statement, KRMC will apply the presumptive financial assistance amount to the Self-Pay Balance.

Approval for financial assistance using this presumptive eligibility method will remain valid for one (1) year. It will apply to the accounts for services for which the determination was made, and to accounts for services performed during that one (1) year period, unless the patient makes a later application for financial assistance or KRH has reason to believe that the financial circumstances of the patient have changed.

LIMITATION ON THE AMOUNT OF A PATIENT'S SELF-PAY BALANCE ONCE FOUND TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE

In all situations, once the patient is determined to qualify for financial assistance, that individual will not be responsible for paying more for Emergency Care or other Medically Necessary Care than the Amounts Generally Billed ("AGB") to individuals who have insurance covering that same care. This means the patient's Self-Pay Balance will not exceed the AGB. KRH may change the methodology for calculating AGB in the future. Any member of the public may obtain a copy of the AGB methodology that is in current use, free of charge, either over the phone by calling 1-406- 756-4408 (an automated line), off the KRH website (www.kalispellregional.org/krmc/) under the tab "Financial Assistance", or by mail addressed to Patient Business Services, 310 Sunnyview Lane, Kalispell, MT 59901, ATTN: AGB Methodology Request.

CATASTROPHIC EVENT ACCOUNTS

A. Patients who do not apply for, or do not qualify for, financial assistance under the above guidelines, but whose Self-Pay Balance is considered catastrophic will be separately considered for financial assistance based on individual circumstances. A Self-Pay Balance is considered catastrophic if the Self-Pay Balance is more than Fifty Thousand Dollars ($50,000). If this is the case, Patient Business Services will contact the patient, if discussions with the patient about the situation have not already taken place. The

patient will be asked to provide to KRH the same information as is used to determine eligibility for financial assistance in other situations. If KRH finds that the patient has no identified means to pay the amount of the patient's Self-Pay Balance in full, taking into account other payment options, the following guidelines will be utilized:The Self-Pay Balance will be equal to the current Medicare reimbursement amount for the particular service.

B. Other factors, such as Family Assets, total family medical debt, future earnings potential, loss of wages and total personal debt may be considered to increase or reduce the amount of financial assistance.

C. A Self-Pay Balance that is reduced under this category of financial assistance must have the Self-Pay Balance paid within ninety (90) days from the time of the financial assistance determination unless other payment arrangements have been agreed to with KRH.

All cases under this section must be approved by the KRH Chief Financial Officer.

PROMPT PAY DISCOUNTS FOR A PATIENT'S SELF-PAY BALANCE

All patients may take advantage of a prompt pay discount. A fifteen percent (15%) discount of the Self-Pay Balance is available for payment in full at or before the date of discharge. A ten percent (10%) prompt payment discount is available if a Self-Pay Balance is paid in full within thirty (30) days of the first post discharge/date of service billing.

OVERALL LIMITATION ON THE AMOUNT OF A SELF-PAY BALANCE FOR PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

Once a patient has been determined to be eligible for financial assistance, that patient's Self-Pay Balance (a) will be less than the gross charges for the services to which the financial assistance determination applies, and (b) will not exceed the AGB for that care. If KRH collects an amount in excess of this limiting amount, it will promptly refund the excess amount to the patient once that fact is known.

OTHER DISCOUNT SITUATIONS

The acceptance by KRH of an amount less than the full balance owed of a Self-Pay Balance as payment in full of the Self-Pay Balance, irrespective of a patient's financial situation, will not be offered routinely. However, either KRH or a patient may initiate consideration of a discount for situations other than financial need. Such a discount may be offered or agreed to when it is in the best interests of KRH, as approved by the Patient Business Services Director or by the KRH Chief Financial Officer.

DEFINITIONS OF TERMS

1. Amounts Generally Billed or AGB – means amounts generally billed for Emergency Care or other Medically Necessary Care to individuals who have insurance covering that same care. In determining AGB, KRH has chosen to use the "Look-Back Method", in which AGB is based on Medicare fee for service payment amounts and the amounts paid by private health insurers (including health benefits plans whether or not insured), as outlined in Internal Revenue Code regulations.
2. Application Period – means the period of time during which KRH must accept and process an application for financial assistance under the Financial Assistance Policy. The Application Period begins when the patient files an application for financial assistance and ends on the 240th day after KRH provides the first post-discharge or post service billing statement to the patient.
3. Emergency Care – means medical treatment for an emergency medical condition, which is (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious

jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant woman who is having contractions, (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child. KRH has a separate policy on the provision of Emergency Care consistent with federal law.

4. Family Assets – means items of property owned or under the effective control of the patient or Responsible Person, such as real estate that has value above any legitimate debt secured by that real estate (but the patient's primary residence and primary automobile are not considered assets), securities (such as stocks, bonds, mutual funds), savings accounts, checking accounts, retirement accounts, secondary automobiles, boats, recreational vehicles and other vehicles, and other assets (such as agricultural or recreational land), which are considered by KRH as available to pay the patient's medical expenses.
5. Gross Charge – Means the full, established price for medical care that KRH Providers consistently and uniformly charges patients before applying any contractual allowances, discounts or deductions to that price. It also can be called the chargemaster rate
6. KRH Providers – means Kalispell Regional Healthcare and its hospitals Kalispell Regional Medical Center ("KRMC") and The HealthCenter ("THC"), and Northwest Orthopedics and Sports Medicine ("NOSM"), as well as their employed physicians and other healthcare services providers.
7. Medically Necessary Care – means a medically necessary service or treatment which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which: (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction. A service or item is not medically necessary if there is another service or item for the recipient that is equally safe and effective and substantially less costly, including, when appropriate, no treatment at all. Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary. An elective or cosmetic surgery or treatment is not medically necessary.
8. Patient – means the person who receives the hospital or other medical care covered by this Policy, as well as that person's Responsible Party when the context requires.
9. Patient's Family – A Patient's Family is defined as the patient, the patient's spouse or domestic partner, and dependent children.
10. Patient's Family Income – means all resources (income plus the Family Assets) of the Patient's Family.
11. Responsible Party – Means the person or persons who may be responsible for payment of the Self-Pay Balance of a patient, whether instead of the patient (such as the parents of a minor child) or in a representative capacity for the patient (such as a legal guardian or attorney in fact).
12. Self-Pay Balance – Means the amount remaining to be paid by the patient or Responsible Party after all other sources of payment have been received or taken into account (such as health insurance or health plans payments, claims of responsibility against third parties, governmental health care plan payments [like Medicare or Medicaid], or discounts allowed under this Policy). For a patient who has health insurance or health plan coverage, it commonly will be the co-pay, co-insurance and deductible amounts that the patient is to pay. The Self-Pay Balance is also considered to be the amount "charged" to the patient under this Policy.

KALISPELL REGIONAL HEALTHCARE

KRH Financial Assistance Adjusted Income Schedule

effective 1/25/16

Discount %	Family Size 1		Family Size 2		Family Size 3		Family Size 4	
	Low	High	Low	High	Low	High	Low	High
100%	$0	$24,947	$0	$33,641	$0	$42,335	$0	$51,029
95%	$24,948	$26,135	$33,642	$35,243	$42,336	$44,351	$51,030	$53,459
90%	$26,136	$27,323	$35,244	$36,845	$44,352	$46,367	$53,460	$55,889
85%	$27,324	$28,511	$36,846	$38,447	$46,368	$48,383	$55,890	$58,319
80%	$28,512	$29,699	$38,448	$40,049	$48,384	$50,399	$58,320	$60,749
75%	$29,700	$30,887	$40,050	$41,651	$50,400	$52,415	$60,750	$63,179
70%	$30,888	$32,075	$41,652	$43,253	$52,416	$54,431	$63,180	$65,609
65%	$32,076	$33,263	$43,254	$44,855	$54,432	$56,447	$65,610	$68,039
60%	$33,264	$34,451	$44,856	$46,457	$56,448	$58,463	$68,040	$70,469
55%	$34,452	$35,639	$46,458	$48,059	$58,464	$60,479	$70,470	$72,899
50%	$35,640	$36,827	$48,060	$49,661	$60,480	$62,495	$72,900	$75,329
45%	$36,828	$38,015	$49,662	$51,263	$62,496	$64,511	$75,330	$77,759
40%	$38,016	$39,203	$51,264	$52,865	$64,512	$66,527	$77,760	$80,189
35%	$39,204	$40,391	$52,866	$54,467	$66,528	$68,543	$80,190	$82,619
30%	$40,392	$41,579	$54,468	$56,069	$68,544	$70,559	$82,620	$85,049
25%	$41,580	$42,767	$56,070	$57,671	$70,560	$72,575	$85,050	$87,479
20%	$42,768	$43,955	$57,672	$59,273	$72,576	$74,591	$87,480	$89,909
15%	$43,956	$45,143	$59,274	$60,875	$74,592	$76,607	$89,910	$92,339
10%	$45,144	$46,331	$60,876	$62,477	$76,608	$78,623	$92,340	$94,769
5%	$46,332	$47,519	$62,478	$64,079	$78,624	$80,639	$94,770	$97,199
0%	$47,520	and up	$64,080	and up	$80,640	and up	$97,200	and up

Discount %	Family Size 5		Family Size 6		Family Size 7		Family Size 8	
	Low	High	Low	High	Low	High	Low	High
100%	$0	$59,723	$0	$68,417	$0	$77,132	$0	$85,868
95%	$59,724	$62,567	$68,418	$71,675	$77,133	$80,805	$85,869	$89,957
90%	$62,568	$65,411	$71,676	$74,933	$80,806	$84,478	$89,958	$94,046
85%	$65,412	$68,255	$74,934	$78,191	$84,479	$88,151	$94,047	$98,135
80%	$68,256	$71,099	$78,192	$81,449	$88,152	$91,824	$98,136	$102,224
75%	$71,100	$73,943	$81,450	$84,707	$91,825	$95,497	$102,225	$106,313
70%	$73,944	$76,787	$84,708	$87,965	$95,498	$99,170	$106,314	$110,402
65%	$76,788	$79,631	$87,966	$91,223	$99,171	$102,843	$110,403	$114,491
60%	$79,632	$82,475	$91,224	$94,481	$102,844	$106,516	$114,492	$118,580
55%	$82,476	$85,319	$94,482	$97,739	$106,517	$110,189	$118,581	$122,669
50%	$85,320	$88,163	$97,740	$100,997	$110,190	$113,862	$122,670	$126,758
45%	$88,164	$91,007	$100,998	$104,255	$113,863	$117,535	$126,759	$130,847
40%	$91,008	$93,851	$104,256	$107,513	$117,536	$121,208	$130,848	$134,936
35%	$93,852	$96,695	$107,514	$110,771	$121,209	$124,881	$134,937	$139,025
30%	$96,696	$99,539	$110,772	$114,029	$124,882	$128,554	$139,026	$143,114
25%	$99,540	$102,383	$114,030	$117,287	$128,555	$132,227	$143,115	$147,203
20%	$102,384	$105,227	$117,288	$120,545	$132,228	$135,900	$147,204	$151,292
15%	$105,228	$108,071	$120,546	$123,803	$135,901	$139,573	$151,293	$155,381
10%	$108,072	$110,915	$123,804	$127,061	$139,574	$143,246	$155,382	$159,470
5%	$110,916	$113,759	$127,062	$130,319	$143,247	$146,919	$159,471	$163,559
0%	$113,760	and up	$130,320	and up	$146,920	and up	$163,560	and up

Discount %	Family Size 9		Family Size 10		Family Size 11		Family Size 12	
	Low	High	Low	High	Low	High	Low	High
100%	$0	$94,604	$0	$103,340	$0	$112,076	$0	$120,812
95%	$94,605	$99,109	$103,341	$108,261	$112,077	$117,413	$120,813	$126,565
90%	$99,110	$103,614	$108,262	$113,182	$117,414	$122,750	$126,566	$132,318
85%	$103,615	$108,119	$113,183	$118,103	$122,751	$128,087	$132,319	$138,071
80%	$108,120	$112,624	$118,104	$123,024	$128,088	$133,424	$138,072	$143,824
75%	$112,625	$117,129	$123,025	$127,945	$133,425	$138,761	$143,825	$149,577
70%	$117,130	$121,634	$127,946	$132,866	$138,762	$144,098	$149,578	$155,330
65%	$121,635	$126,139	$132,867	$137,787	$144,099	$149,435	$155,331	$161,083
60%	$126,140	$130,644	$137,788	$142,708	$149,436	$154,772	$161,084	$166,836
55%	$130,645	$135,149	$142,709	$147,629	$154,773	$160,109	$166,837	$172,589
50%	$135,150	$139,654	$147,630	$152,550	$160,110	$165,446	$172,590	$178,342
45%	$139,655	$144,159	$152,551	$157,471	$165,447	$170,783	$178,343	$184,095
40%	$144,160	$148,664	$157,472	$162,392	$170,784	$176,120	$184,096	$189,848
35%	$148,665	$153,169	$162,393	$167,313	$176,121	$181,457	$189,849	$195,601
30%	$153,170	$157,674	$167,314	$172,234	$181,458	$186,794	$195,602	$201,354
25%	$157,675	$162,179	$172,235	$177,155	$186,795	$192,131	$201,355	$207,107
20%	$162,180	$166,684	$177,156	$182,076	$192,132	$197,468	$207,108	$212,860
15%	$166,685	$171,189	$182,077	$186,997	$197,469	$202,805	$212,861	$218,613
10%	$171,190	$175,694	$186,998	$191,918	$202,806	$208,142	$218,614	$224,366
5%	$175,695	$180,199	$191,919	$196,839	$208,143	$213,479	$224,367	$230,119
0%	$180,200	and up	$196,840	and up	$213,480	and up	$230,120	and up

2016 HHS Poverty Guidelines

HH size	2016
1	$11,880
2	$16,020
3	$20,160
4	$24,300
5	$28,440
6	$32,580
7	$36,730
8	$40,890
9	$45,050
10	$49,210
11	$53,370
12	$57,530

(add $4,160 for ea addtl HH member)

Financial Assistance Application Checklist

Please make certain the following documents accompany your application to ensure timely processing.

☐ **Please ensure you have signed and dated your application?**

☐ **Current Federal and State tax returns please include all pages with your W-2(s). If you have not enclosed a copy of your tax return, you must complete the section of the application explaining why this wasn't included?**

☐ **Copy of your most recent pay stub(s).**

☐ **Copy of Social Security Award Letter, if applicable.**

☐ **Copy of Unemployment Award Letter, if applicable.**

☐ **Copies of current investment account statements including pensions, savings, CDs, stocks, etc.**

☐ **Copies of last 3 bank statements.**

Kalispell Regional Healthcare strives to assist patients by fairly and accurately establishing your eligibility for financial assistance. Please assist this process by providing the required paperwork timely. Missing information can cause your request for assistance to be denied.

KALISPELL REGIONAL HEALTHCARE

Date; _____

Clinic: _____

Rep:_____

Completion of this Financial Assistance Application will allow us to determine if Kalispell Regional Healthcare is able to consider reduced payments based on financial need.

Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Your signature authorizes Kalispell Regional Healthcare to verify information provided in this financial statement by obtaining a credit report and/or other financial information.

Patient Name	SSN	Date of Birth
Address	City/State	Zip Code
Home Telephone	Work Telephone	Cell
Employer	Position	Date of Employment
Insurance	Policy #	
Spouse/Significant Other Name	SSN	Date of Birth
Address (if different from Patient)	City/State	Zip Code
Spouse/Significant Other's Employer	Position	Date of Employment
E-Mail	**Number of Dependents on Tax Return**	**Total Household Size**

Monthly Income:	Yourself	Spouse/significant other
Employment/Gross Wages		
Social Security/Pension Income		
Public Assistance		
Unemployment Benefits		
Alimony/Child Support		
Worker's Compensation		
Any other sources of Income (describe)		
Total Monthly Income		

KALISPELL REGIONAL HEALTHCARE

Please return the completed form and documentation of yearly household income within ten days. Your most recent tax return is the best source to document your income. Any attachments to returns of Schedules must be included.

If you have any questions or are unable to provide complete information, please contact us at 406-752-1767.

Assets:

Cash/Checking/Savings Balance	$
Stocks/Bonds/IRA/401K	$
Cash Value of Life Insurance	$
Auto 1	
Year/Make	
Model	
Value	$
Loan Balance	$
Auto 2	
Year/Make	
Model	
Value	$
Loan Balance	$
Current Home Value	$
Purchase Date	
Purchase Price	$
Mortgage Loan Balance	$
Other Property (Describe)	$
Recreational Merchandise	$
Other Assets (Describe)	$
Total Assets	$

Monthly Expenses:

Rent or House Payment	$
Utilities	$
Telephone	$
Cable	$
Groceries	$
Prescriptions	$
Childcare	$
Child Support	$
Monthly Payment (Auto 1)	$
Monthly Payment (Auto 2)	$
Vehicle Insurance	$
Vehicle Maintenance/Gasoline	$
Health Insurance	$
Life Insurance	$
Other Loan payments	$
Payments on Credit Cards	$
	$
	$
Payments on Medical Bills	$
	$
	$
	$
Total Monthly Expenses	$

Additional Information:

If you are not able to provide the information on this application please explain.

If you have no income, please explain how you meet your daily expenses.

If your annual household income has increased or decreased from the past year to this current year, please explain.

Please provide any additional information about any other circumstances that you think will better help us to understand your situation.

To return in person or to contact a Customer Service Representative

Return application:
Kalispell Regional Medical Center
Attn: Financial Advising Dept.
310 Sunnyview Lane
Kalispell, MT 59901
Financial Advisors 406-752-1767

Telephone Numbers:
Customer Service & Statement Questions
please contact patient accounts at 406-756-4408
Toll Free in the U.S. 844-349-7900
In Canada: 844-349-7900

Revised 07/26/17