Shoshone MEDICAL CENTER
25 Jacobs Gulch, Kellogg, Idaho, 83837 * 208-784-1221

Financial Assistance & Sliding Fee Scale Application

Version No.: 6

Applicant must provide the following documentation to be considered for Shoshone Medical Center's Assistance Programs:

☐ Completed Application form with no omissions.
☐ Photocopy of the most recent Federal Tax Return, including attachments.
☐ Copy of check stubs for the last three (3) months, from place of last employment.
☐ Copy of three (3) months bank statements, checking and savings *****
☐ 1st Denial from State of Idaho Medicaid Assistance Program. *****
(Shoshone Medical Center has the State of Idaho Medicaid applications.)

If the information provided does not reflect the applicant's current financial situation the following documentation may be included.

☐ Statement of disability from State or Federal Agency.
☐ Statement supporting employment status, Unemployment Benefits.
☐ Proof of garnishments, liens, judgements, etc.

All employed members of the household must provide the documentation listed above. Applicant will be notified of decision after all documentation has been reviewed. If documentation is not provided then the application will be denied and account turned to collection agency if payment arrangements are not made.

***Not required for SMC Family Medicine or Emergency Room Visits**

If you have any questions, please call the SMC Business Office at 208-784-1226

Checklist/Summary Shoshone Medical Center Financial Assistance
Attach to completed application upon submission to Business Office Manager/CFO

_____ Completed Application form with no omission

_____ Photo Copy of the most recent Federal Tax Return including attachments

_____ Copy of Check Stubs for the last three months form place of last employment

_____ Bank Statements for past 3 months (Not required for SMC Family Medicine or Emergency Room Visits)

_____ 1st denial from State of Idaho Medicaid Assistance Program (Not required for SMC Family Medicine or Emergence Room Visits)

_____ Annual Income used for Calculation: $_____

_____ Number of people in the household: _____

_____ Total bill amount with itemized statement included: _____

_____ Stay Number(s): _____

_____ Discount Amount to be adjusted off: % _____

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Personal Financial Statement (Confidential)

** In order for SMC to consider your application, all sections of the application must be complete**

I authorize the access and use of any and all information stored with Shoshone Medical Center, including my protected health information (PHI) and personal financial information by the Shoshone Medical Center Financial Assistance Committee. I understand that this information may be used in the decision-making process regarding my qualification for financial assistance. In addition, your signature also authorizes Shoshone Medical Center and Shoshone Foundation to verify information provided in this financial statement and to obtain a Credit Report.

Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Name:	SSN:	DOB:
Spouse's Name:	SSN:	DOB:
Mailing Address:	City/State:	Zip Code:
Physical Address:	City/State:	Zip Code:
Daytime Telephone #	Evening Telephone #	
Applicants Employer:	Position:	Date of Hire:
Average hours worked per week:	If unemployed, last date worked:	
If unemployed and/or not working full-time (32-40 hours per week), please explain why:		
Spouse's Employer:	Position:	Date of Hire:
Average hours worked per week:	If unemployed, last date worked:	
If unemployed and/or not working full-time (32-40 hours per week), please explain why:		
Number of Dependents:	Ages:	
Name of Dependents (First & Last Name):		
Are you covered by any insurance? (Circle one) Yes No		
If uninsured, have you applied for insurance through Idaho Medicaid? Yes No		
If no, why?		
Have you applied for Medicaid benefits or have you been screened for Medicaid benefits? (Not required for SMC Family Medicine or Emergency Room Visits) Yes No		

Assets & Living Expenses do not apply to SMC Family Medicine or Emergency Room Visits

GROSS MONTHLY INCOME	**(BEFORE TAXES AND DEDUCTIONS)**	
Source	**Self**	**Spouse**
Employment		
Commissions/Bonuses/Tips		
Unemployment/Workman's Comp		
SSI or SSDI		
Child Support		
Retirement/Pension		
Other (describe)		
Total (before taxes and deductions)		

ASSETS	
CASH ON HAND	$
CHECKING ACCOUNT BALANCE Provide current statement(s) showing value/balances for all accounts.	$
SAVINGS ACCOUNT BALANCE Provide current statement(s) showing value/balances for all accounts.	$
STOCKS/BONDS/IRA/RETIREMENT/ETC. Provide statement(s) showing value/balances.	$
CASH VALUE OF LIFE INSURANCE	$
AUTO 1: Year/Make: _____ Model: _____	Current Value: $
AUTO 2: Year/Make: _____ Model: _____	Current Value: $
HOME/PROPERTY Purchase Date: _____/_____/_____	Purchase Price: $ Current Value: $
OTHER PROPERTY (DESCRIBE)	Current Value: $
RECREATIONAL MERCHANDISE (DESCRIBE)	Current Value: $

EXPENSES / LIABILITIES	MONTHLY PAYMENTS	ACCOUNT BALANCE
Mortgage/Rent (If no mortgage or rent expense, please explain why)	$	$
Food Do you receive SNAP benefits?	YES / NO (circle one)	If yes, amount per month $ _____
Utilities	$	$
Prescriptions	$	$
Insurance Health Auto Other (specify)	$_____ $_____ $_____	$_____ $_____ $_____
Auto Loan 1	$	$
Auto Loan 2	$	$
Telephone Home cell	$_____ $_____	$_____ $_____
TV/Cable/1nternet	$	$
Personal Loan (specify)	$	$
Other expenses (specify)	$	$
MEDICAL (LIST EACH)	MONTHLY PAYMENTS	ACCOUNT BALANCE
SMC	$	$
	$	$
	$	$
CREDIT CARD (LIST EACH)	MONTHLY PAYMENT	ACCOUNT BALANCE
	$	$
	$	$
	$	$
	$	$
CALCULATE	TOTAL Monthly Payments	TOTAL Account Balance
Total Expenses / Liabilities	$	$

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ADDITIONAL INFORMATION

By filling out this financial assistance application you are indicating that you are unable to meet the Hospital's payment requirements for your account(s). In some cases, we are able to consider reduced payments and/or balance reductions.

Please indicate what type of financial assistance you are applying for (circle one):

Reduced Monthly Payment or Reduction of Balance Owed

If you reported zero income please describe in detail

- How you pay the expenses listed on the financial assistance application and all other daily living expenses, and
- Why you are not working and your efforts in searching for employment.

You may use the back side of this form if additional space is needed for explanation.

If someone assists with your living expenses, provide documentation for the amounts received.

_____

_____

If you did not file a Federal Tax Return, please explain why.

_____

_____

If total expenses exceed income reported, please describe how expenses are met.

_____

_____

REQUIRED DOCUMENTATION CHECKLIST

- Completed financial assistance application
- Complete copy of most current Federal tax return (including schedules and attachments)
- Complete & detailed copy of most current monthly statement(s) for all banking and savings accounts
- Current copy of statement(s) for all Stocks/Bonds/IRA/Retirement/Etc.
- Year-to-date proof of ALL income (current pay stub(s) that shows total gross income for previous 3 months and documentation for all other types of income such as unemployment, child support, social security, pension, disability, etc.)
- Documentation regarding Medicaid denial or approval (uninsured patients only)

Applications without complete and required documentation will be returned.

Please return your Financial Assistance Application in a timely manner. The financial assistance committee only meets once per month. Normal billing and collections will continue through the financial assistance application process. If you need help filling out the application or have questions, please call the Patient Financial Service Rep at (208)784-1226.

Return completed application to: **Shoshone Medical Center**
ATTN: Stacie Gilmore
25 Jacobs Gulch
Kellogg ID 83837

Date Received: _____