

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 \*
  - 1<sup>st</sup> 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**



25 Jacobs Gulch, Kellogg, Idaho, 83837 \* 208-784-1221

## ***Financial Assistance & Sliding Fee Scale Application***

Version No.: 6

### **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)
- \_\_\_\_\_ 1<sup>st</sup> 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: % \_\_\_\_\_



25 Jacobs Gulch, Kellogg, Idaho, 83837 \* 208-784-1221

## Financial Assistance & Sliding Fee Scale Application

Version No.: 6

### 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



25 Jacobs Gulch, Kellogg, Idaho, 83837 \* 208-784-1221

## Financial Assistance & Sliding Fee Scale Application

Version No.: 6

### 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: \$		



25 Jacobs Gulch, Kellogg, Idaho, 83837 \* 208-784-1221

## Financial Assistance & Sliding Fee Scale Application

Version No.: 6

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/internet	\$ _____	\$ _____
Personal Loan (specify)	\$ _____	\$ _____
Other expenses (specify)	\$ _____	\$ _____
<b>MEDICAL (LIST EACH)</b>	<b>MONTHLY PAYMENTS</b>	<b>ACCOUNT BALANCE</b>
SMC	\$ _____	\$ _____
	\$ _____	\$ _____
	\$ _____	\$ _____
<b>CREDIT CARD (LIST EACH)</b>	<b>MONTHLY PAYMENT</b>	<b>ACCOUNT BALANCE</b>
	\$ _____	\$ _____
	\$ _____	\$ _____
	\$ _____	\$ _____
	\$ _____	\$ _____
<b>CALCULATE</b>	<b>TOTAL Monthly Payments</b>	<b>TOTAL Account Balance</b>
Total Expenses / Liabilities	\$ _____	\$ _____



25 Jacobs Gulch, Kellogg, Idaho, 83837 \* 208-784-1221

# Financial Assistance & Sliding Fee Scale Application

Version No.: 6

## 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: \_\_\_\_\_