

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

- Completed Application form with no omissions.
- Self employed submit details of most recent 2 months of income and expenses.
- Copy of pay stubs for the last 2 months, from the last place of employment
- Photocopy of most recent Federal Tax Return and any attachments

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.

No one will be denied access to service due to inability to pay.

If you have any questions, please call the SMC Business Office at 208-784-1470



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

Financial Assistance & Sliding Fee Scale Application (Shoshone Medical Center and SMC Family Medicine)

Version No.: 11

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 most recent Federal Tax Return and any attachments
- _____ 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:		DOB:	
Spouse's Name:		DOB:	
Mailing Address:		City/State:	Zip Code:
Physical Address:		City/State:	Zip Code:
Daytime Telephone #		Evening Telephone #	
Applicants Employer:		Position:	Date of Hire:
Spouse's Employer:		Position:	Date of Hire:
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

GROSS MONTHLY INCOME	(BEFORE TAXES AND DEDUCTIONS)	
	Self	Spouse
Employment		
Commissions/Bonuses/Tips		
Unemployment/Workman's Comp		
SSI or SSDI		



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Child Support		
Retirement/Pension		
Other, rental property, (describe)		
Total (before taxes and deductions)		

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

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.

REQUIRED DOCUMENTATION CHECKLIST

- Completed financial assistance application
- Year-to-date proof of ALL income (current pay stub(s) that shows total gross income for previous 2 months and documentation for all other types of income such as unemployment, child support, social security, pension, disability, etc.)
- Photo copy of most recent Federal Tax Return and any attachment.

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)784-1470. **No one will be denied access to any services due to inability to pay.**

Return completed application to: **Shoshone Medical Center**

ATTN: Jessica Smith

25 Jacobs Gulch

Kellogg, ID 83837

Date Received: _____