Shoshone MEDICAL CENTER 25 Jacobs Gulch, Kellogg, Idaho, 83837 * 208-784-1221	***Financial Assistance & Sliding Fee Scale Application***

Version No.: 4

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.

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

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Date of Service: ______________________

Patient's Name Last First Middle

Patient's Date of Birth Social Security Number (Optional) Home Phone Number

Guarantor Information (Person Responsible for Payment)

Last First Middle Initial Relationship to Patient

Date of Birth Social Security Number (Optional) Home Phone Number

Mailing Address/PO Box City State County Physical Street Address

Current Employer Contact Information Name/Phone Full Time/Part Time

TOTAL Number of People in Patient's Household TOTAL Yearly Income of People in Patient's Household

Income Information

Monthly Income Sources

	Applicant	Spouse		Combined Monthly Income
Employment Income	________	________	=	________
Food Stamps	________	________	=	________
Social Security	________	________	=	________
Disability	________	________	=	________
Unemployment	________	________	=	________
Spousal/Child Support	________	________	=	________
Rental Property	________	________	=	________
Investment Income	________	________	=	________
Other Income (Describe)	________	________	=	________
	Total Combined Monthly Income		=	________

Unemployment: If you do not have a monthly income, please explain how you take care of your monthly expenses:

Asset & Living Expenses do NOT apply to SMC Clinic & Emergency Department Patients

***Assets**

Do you own Property other than your Primary Residence? Y/N ____________

Do you own any Recreational Vehicles? Y/N ____________

Checking/Money Market/Savings Accounts

Bank	Current Balance	Bank Name	Current Balance
____________	$____________	____________	$____________
____________	$____________	____________	$____________
____________	$____________	____________	$____________

***Estimated Monthly Living Expenses:**

House/Mortgage	$____________	List Other Monthly Payments	
Property Taxes	$____________	____________	$____________
Home Owners Insurance	$____________	____________	$____________
Utilities (Electric, Gas, Water)	$____________	____________	$____________
Garbage	$____________		
Food	$____________	Total Monthly Payments	$____________
Telephone	$____________		
Child Support	$____________		
Spousal Support/Alimony	$____________		
Child Care	$____________		
Health Insurance Premium	$____________		
Medicare Part D	$____________		
Automobile Insurance Premium	$____________		
Automobile Payment	$____________		
Automobile Gas	$____________		
Medical/Dental/Prescriptions	$____________		
Credit Cards	$____________	Credit Limit on Credit Cards	$____________
Liens/Wage Garnishments	$____________		

ALL PATIENTS OR GUARANTOR MUST SIGN

I certify that all information is true and complete and hereby authorize Shoshone Medical Center to request a credit check report and/or verify any of the above information as deemed necessary.

____________________ ____________

Applicant Signature **Date**

Return complete application to: Shoshone Medical Center, Business Office, 25 Jacobs Gulch, Kellogg, ID 83837 PH (208) 784-1226 FAX (208) 784-1462