Logan Health – Shelby
640 Park Avenue | Shelby, MT 59474 | (406) 434-3200

FINANCIAL ASSISTANCE PROGRAM

Applications must be completed in full to be eligible, please read carefully.

Application is to include:

1. Medicaid Denial or Signed Attestation Statement
2. Proof of income for the entire household
- **2.1 Most recent tax return**
- **2.2 Bank Statements for previous 3 months**
- **2.3 Pay Stubs for previous 3 months**
- **2.4 Financial Hardship Applications: All outstanding bills**

Patient Financial Services Manager, Finance, or the President, will approve or deny all applications.

Dated _____

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Financial Assistance Policy Work Sheet

All other sources of possible payment must be exhausted before this office will consider any Financial Assistance Policy. You are expected to apply for any Public Assistance, Supplemental Security Income, and/or Medicare which may be eligible to you.

PATIENT _____ PHONE _____
ADDRESS _____ MSG OR CELL _____
_____ SIZE OF HOUSEHOLD _____

HOUSEHOLD INFORMATION: (Individual applicant has financial responsibility)

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE/MED COVERAGE YES_____ NO_____ TYPE_____
(Only Applicants above 200% of the HHS Poverty Guidelines will need to complete the Household Monthly Expenses)

HOUSEHOLD MONTHLY INCOME
Wages _____
Social Security Benefits _____
Unemployment Benefits _____
Workers Comp Benefits _____
Pension _____
Child Support _____
Alimony _____
Any Other (please list) _____
_____
_____
TOTAL MONTHLY INCOME:
$_____

HOUSEHOLD MONTHLY EXPENSES
Rent/House payment _____
Utilities _____
Personal Items _____
Auto Payment _____
Insurances _____
Medical Expenses _____
Credit Cards (list) _____
Loan Payments list) _____
Other _____
TOTAL MONTHLY HOUSEHOLD EXPENSES:
$ _____

This is to certify that I am unable to meet my financial obligation to the Logan Health – Shelby for medical services rendered. Completion of this form is my request for assistance to help satisfy my obligations. The completion of this form does not guarantee assistance will be provided. I further certify that the information given on this form is true and correct to the best of my knowledge. I agree to provide copies of documents supporting the above information as requested by this office.

Patient/Guarantor: _____ Date: _____
Witness Signature: _____ Date: _____

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Office Use Only:
Approved (%):
_____
Not Approved:
_____
Signature of PFS, Finance, or President:
_____

Additional Information: (Unemployment Statement, Bank Account Documentation)

LOGAN HEALTH

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ATTESTATION STATEMENT
(Check all that apply)

__ I am not age 65 or older, blind, disabled, pregnant; nor do I have a dependent child under the age of 19 in my home.

__ My yearly income does not exceed 200% of the Federal Income Poverty Guideline.

__ I live out of state and do not qualify for Montana Medicaid.

Patient: _____ Dated: _____

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	**100%**	**125%**	**150%**	**175%**	**200%**	**>200%**
Family Size	**100% discount**	**80% discount**	**60% discount**	**40% discount**	**20% discount**	**0% discount**
1	$13,590	16,988	20,385	23,783	27,180	30,578
2	$18,310	22,888	27,465	32,043	36,620	41,198
3	$23,030	28,788	34,545	40,303	46,060	51,818
4	$27,750	34,688	41,625	48,563	55,500	62,438
5	$32,470	40,588	48,705	56,823	64,940	73,058
6	$37,190	46,488	55,785	65,083	74,380	83,678
7	$41,910	52,388	62,865	73,343	83,820	94,298
8	$46,630	58,288	69,945	81,603	93,260	104,918
For each additional person, add	$4,720	$5,900	$7,080	$8,260	$9,440	$10,620

*Based on 2022 HHS Poverty Guidelines (http://aspe.hhs.gov/poverty/14poverty.shtml)

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