

Whitefish

1600 Hospital Way | Whitefish, MT 59937 | (406) 863-3500

Dear

Enclosed you will find an application for Financial Assistance.

To apply for the assistance program you need to complete the enclosed application.

Please make sure to sign and date all pages where a signature is required. If your income is greater than 200% of the Federal Poverty Guideline, you will also need to apply for Medicaid through the Department of Public Health & Humana services. Their contact information is at the end of this letter. We will need a copy of the determination letter from Medicaid to process the application for financial assistance.

Please return the financial assistance application for Logan Health *Whitefull* back with Proof of your household income for three months, three months of bank statements, Blue Book print out of the value of your vehicle and a list of assets. Total assets limit is \$1500.00 for one person add \$500.00 for each additional family member, if you are over the assets limit you will not qualify for help.

The amount of the write-off will then be figured according to income and is based on a sliding scale; you must be at or below the poverty guideline. You are then responsible for 12 payments in the amount according to the determination. The Medicaid number is 888-706-1535 for any questions you may call their office directly, or visit your local Medicaid office.

If you prefer to just set-up a payment plan please call 406-751-6445 to patient business services, we would be happy to help you with the payment plan.

Sincerely,

Holly Miley or Lisa Harbaugh Financial Counselor Logan Health *Whitefish* 406-863-3727 or 863-3567 Fax # 406-863-3732 or 863-3595 Logan Health - Whitefish will give a reasonable dollar amount of its services without charge to eligible persons who cannot afford to pay for care. All Medically Necessary services will qualify for financial assistance consideration, including any hospital-owned physician services received at Logan Health - Whitefish or off-site locations.

To be eligible to receive Financial Assistance, your family income must be at or below 400% the Federal Poverty Income Guidelines. Federal Poverty Guidelines can be found at <u>https://aspe.hhs.gov/poverty-guidelines</u>.

If you think you may be eligible for Financial Assistance, please contact the Business Office as soon as possible. The Business Office will instruct you as to the requirements that must be met prior to application. For your convenience you may also review and download the Financial Assistance Application on line at <u>www.nvhosp.org</u>.

I hereby acknowledge that I have received the Notice of Availability of Financial Assistance, and that it is my responsibility to contact the Business Office for further information. This is a notice only and will not be considered as a dated application for Financial Assistance.

Patient or	Represen	tative
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Date/Time

Witness

Date/Time

Approved BOD: 04/2019

LOGAN		Applicant Name:
Whilefish 1600 Hospital Way • Whitefish, MT 59937	FINANCIAL ASSISTANCE FORM	
* C C A *	CCA-7 Rev. 08/21 1 of 8	

_				Logan Health - Whitefish	- Whitefish				
			Patien	Patient Assistance Eligibility Guidelines	ligibility Guide	lines			
				Sliding Fee Schedule	Schedule				
					ECUC				
		GLOSS M	ionthly Income	Gross Monthly Income as a Percentage of Federal Poverty Gi	age of Federal	Poverty Guide	uidelines		
		A	Annual Income						
Family Size	100% or less	100% or less 150% or less 200% or less 400% or less	2000% or loss	1000/ 05 1000				IICOITIE	
v	A 1000	020 10 07 001		400% OF less		100% or less	150% or less	150% or less 200% or less 400% or less	10% or less
	4,000	0/8/17	29,160	58,320		\$ 1,215	1,823	2,430	4.860
~	19,720	29,580	39,440	78,880		1.643		2 26 2	0 570
ω	24,860	37,290	49.720	99 440		0 C C C		0,401	0,070
4	30 000			00,0	_	2,012	3, 108	4,143	8,287
л.		40,000	000,000	120,000		2,500	3,750	5,000	10,000
	35,740	52,710	70,280	140,560		2,928	4,393	5.857	11 713
σ	40,280	60,420	80,560	161,120		3.785		A 742	10 01
7	45,420	68,130	90.840	181 680		A 040		1 0, - 10	10,421
ω	50 580	75 010	101 100			4,213	2,0,0	1,5/0	15,140
		040/0	101,120	202,240		4,642	6,320	8,427	16,853
To ut charges									
Adjusted Off	100%	75%	65%	44%		100%	75%	65%	A A OZ
								00.70	0/ 뉴누
Based on 2023 Federal Poverty Guidelines	Federal Povert	y Guidelines							

Resources provided by: https://aspe.hhs.gov/poverty-guidelines

PATIENT ASSISTANCE SLIDING FEE SCHEDULE



LOGAN

Whitefish

CCA-5 Rev. 04/2023 1 of 1 Patient Name: \_

Responsible Party: \_\_\_\_\_

Pt. Account # \_\_\_\_\_

4. FOR OFFICE USE ONLY

# of Dependents: \_\_\_\_\_

1. INCOME	2. E	EXPENSES
Description Monthly Income	Description	Monthly Expenses
A. GROSS SALARY	A. Rent or House Payment	
Husband	B. Food	
Net Salary - Husband	C. Utilities (Elect., Water, Etc.)	
Employer	D. Repairs (Car, Home)	
B. GROSS SALARY	E. Installment Loans	
Wife	F.	
Net Salary - Wife	G. Car Payment	
Employer	H. Visa	
C. Dividend and Interest	I. Master Card	
D. Rental Income	J. Sears	
E. Pension Income	K. Others - List	
F. Self Emp. Income	L. Clothing	
G. Social Security Benefits	M. Travel	
H. V.A. Benefits	N. Education (college)	
I. Welfare	O. Others - List	
J. Child Support or Alimony	P. Total Expenses per month	
K. Others - List		
L		
M		
N. Total Income per month		
O. Did you apply for the Affordable Care Act?		

## 3. STOP: ASSETS (Applicable only to families above 200% of the Federal Poverty Guidelines)

Description	Value or Amount	Summary and Analysis Description	Amount
A. Checking Account - Name of bank		1. Total Income per month (line N)	
B. Savings Account - Name of bank		2 Total European per month (line D)	
C. IRA			
D. Insurance Policy (cash value)		A. Patients Liability for hospital bill	
E. Home			
F. Car		Arrangement Agreed Upon through analysis of li	nes 3 and 4 above:
G. Others - List:			
Н			
I. Total Assets			
		Financial Counselor	
Approved By:		I Certify the Above Information is True	e and Accurate.
Date:		·	
		Patient Signature	
LOGAN		Applicant Name:	
illhildish <b>FINA</b> Hospital Way • Whitefish, MT 59937	NCIAL ASSISTANCE FORM		
	CCA	7	
	Rev. 08/2	1	

Applicant Name:			
Co-Applicant Name:			
Patient Name(s):		Date of Birth:	
Applicant's Mailing Address:			
Home Phone:		Work Phone:	
Number of persons in your fa	amily (for tax purposes):		
	Applicant	Co-Applicant	
Social Security #:			
Employer:			
Employer Address:			
Work Phone:			
Has any patient listed above	applied for Medicaid for u	npaid hospital accounts?	
Has any patient listed above	applied for Medicaid for u	npaid hospital accounts?	
Has any patient listed above If no, why not?			
If no, why not?	□ Yes		
If no, why not?	□ Yes		
If no, why not? Is any patient listed eligible for Has any patient listed ever a	☐ Yes or VA medical benefits? ☐ Yes	□ No	stance
If no, why not? Is any patient listed eligible for Has any patient listed ever a	☐ Yes or VA medical benefits? ☐ Yes	□ No	stance
If no, why not? Is any patient listed eligible fo Has any patient listed ever a	☐ Yes or VA medical benefits? ☐ Yes applied to the Logan Healt ☐ Yes	☐ No ☐ No h - Whitefish Community Financial Assis	stance
If no, why not? Is any patient listed eligible fo Has any patient listed ever a program before?	☐ Yes or VA medical benefits? ☐ Yes applied to the Logan Healt ☐ Yes	☐ No ☐ No h - Whitefish Community Financial Assis	stance
If no, why not? Is any patient listed eligible for Has any patient listed ever a program before? If yes, what was the	☐ Yes or VA medical benefits? ☐ Yes applied to the Logan Healt ☐ Yes status?	□ No □ No h - Whitefish Community Financial Assis □ No	stance
If no, why not? Is any patient listed eligible for Has any patient listed ever a program before? If yes, what was the	□ Yes or VA medical benefits? □ Yes applied to the Logan Healt □ Yes status? □ Approved	□ No □ No h - Whitefish Community Financial Assis □ No	stance
Is any patient listed eligible for Has any patient listed ever a program before? If yes, what was the	☐ Yes or VA medical benefits? ☐ Yes applied to the Logan Healt ☐ Yes status? ☐ Approved	□ No □ No h - Whitefish Community Financial Assis □ No □ Denied	stance

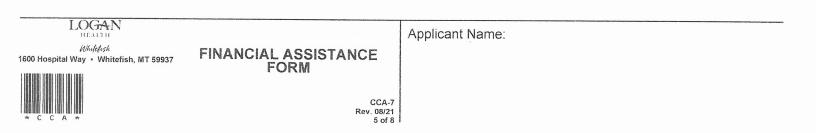
## **SECTION II: Income**

Gross income for the 12 month immediately preceding the month in which you are applying is the preferable amount. If this information is unavailable or unattainable, you may list gross income for a lesser number of months, but not less than three months.

For the categories listed below please itemize the total gross income received for the number of months indicated in the past year:

	3 Months	12 Months
Wages		
Self-Employment		
Pension/Retirement		
Military Allowance		
Unemployment Compensation		
Disability		
Alimony/Child Support		
Public Assistance/Medicaid		
Social Security	۰	
Farm Income		
Worker's Compensation		
Rental Income		
Other Dividends		
Other Income (list)		

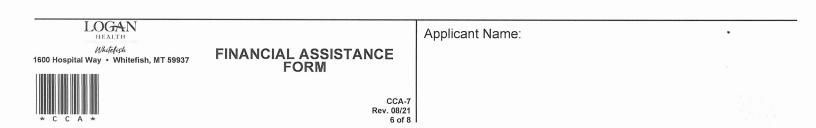
Provide verification for the amounts state above. Partial months will not count.



## **SECTION III: Assets**

STOP: Do no complete if family income is 200% or less of the Federal Poverty Guidelines.

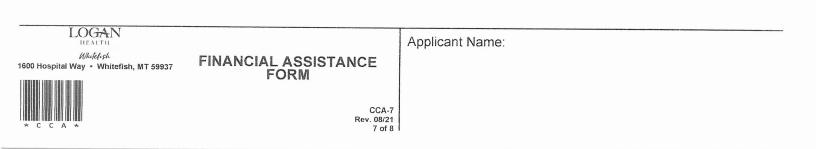
Cash on hand:	
Cash on deposit in checking accounts:	
1. Bank or Institution:	
Address:	
Account #:	
2. Bank or Institution:	
Address:	
Account #:	
Cash on deposit in savings accounts:	
Bank or Institution:	
Address:	
Account #:	
Cash on deposit in CD (Certificate of Deposit) or Money Market accounts:	
Bank or Institution:	
Address:	
Account #:	
Cash invested in IRA or KEOGH accounts:	
Bank or Institution:	
Address:	
Account #:	



I certify that the above information is true and accurate to the best of my knowledge. Further, I have made application for any assistance (Medicare, Medicaid, VA, insurance, etc.) which was available for payment of my hospital charges and I took any action necessary to obtain this assistance and was denied. I understand any charges that are not covered because of my non-compliance with the agency/insurance requirements will not be considered under this program.

I understand that this application is made so that the hospital can determine my eligibility for uncompensated services under its Community Funded Care program. If any information I have given is untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature	Date of Request
Co-Applicant's Signature	Date of Request
FOR HOSPITAL USE ONLY: Date Received:	
Determination:	
Determination made by:	
Reason, if denied:	



- 1. Are you looking for work? Describe your efforts.
- 2. When do you expect to be employed?
- 3. If you are not currently looking for work, please explain. When do you expect to look for work?
- 4. Does someone provide you with housing, food, clothing, or cash? If so, please list their names, address and phone number.

Housing:	 	 	
Food:	 	 	
Clothing:	 	 	
Cash:	 	 	

- 5. If you have no income and are not receiving help from friends or relatives, please explain:
  - A. How do you pay rent?
  - B. How do you buy food?
  - C. What do you do for cash?

Applicant's Signature

Date/Time

