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 *Whitefish* 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

EFFECTIVE - October 6th, 2020

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 https://aspe.hhs.gov/poverty-guidelines .

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 www.nvhosp.org .

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 Representative ______________________ Date/Time ____________

Witness ______________________ Date/Time ____________

Approved BOD: 04/2019

Logan Health - Whitefish

Patient Assistance Eligibility Guidelines

Sliding Fee Schedule

2023

Gross Monthly Income as a Percentage of Federal Poverty Guidelines

	Annual Income				Monthly Income			
Family Size	100% or less	150% or less	200% or less	400% or less	100% or less	150% or less	200% or less	400% or less
1	$ 14,580	21,870	29,160	58,320	$ 1,215	1,823	2,430	4,860
2	19,720	29,580	39,440	78,880	1,643	2,465	3,287	6,573
3	24,860	37,290	49,720	99,440	2,072	3,108	4,143	8,287
4	30,000	45,000	60,000	120,000	2,500	3,750	5,000	10,000
5	35,140	52,710	70,280	140,560	2,928	4,393	5,857	11,713
6	40,280	60,420	80,560	161,120	3,785	5,035	6,713	13,427
7	45,420	68,130	90,840	181,680	4,213	5,678	7,570	15,140
8	50,560	75,840	101,120	202,240	4,642	6,320	8,427	16,853
% of Charges								
Adjusted Off	100%	75%	65%	44%	100%	75%	65%	44%

Based on 2023 Federal Poverty Guidelines

Add $5,140 or each additional family member

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

PATIENT ASSISTANCE SLIDING FEE SCHEDULE

Patient Name: ______________________ Pt. Account # ______________________

Responsible Party: ______________________ # of Dependents: ______________________

1. INCOME		2. 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? ☐ Yes ☐ No			

3. STOP: ASSETS (Applicable only to families above 200% of the Federal Poverty Guidelines)		4. FOR OFFICE USE ONLY	
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 Expenses per month (line P)	
C. IRA		3. Excess Income per month (line 1-2)	
D. Insurance Policy (cash value)		4. Patients Liability for hospital bill	
E. Home			
F. Car			
G. Others - List: ______			
H. ______			
I. Total Assets			

Arrangement Agreed Upon through analysis of lines 3 and 4 above:

____
Financial Counselor

Approved By: ______________________

I Certify the Above Information is True and Accurate.

Date: ______________________

____
Patient Signature

LOGAN HEALTH Whitefish
1600 Hospital Way • Whitefish, MT 59937

FINANCIAL ASSISTANCE FORM

Applicant Name:

SECTION I- Applicant/Account Information

Applicant Name: ____________________

Co-Applicant Name: ____________________

Patient Name(s): ____________________ Date of Birth: ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Applicant's Mailing Address: ____________________

Home Phone: ____________________ Work Phone: ____________________

Number of persons in your family (for tax purposes): ____________________

	Applicant	Co-Applicant
Social Security #:		
Employer:		
Employer Address:		
Work Phone:		

Has any patient listed above applied for Medicaid for unpaid hospital accounts?

☐ Yes ☐ No

If no, why not? ____________________

Is any patient listed eligible for VA medical benefits?

☐ Yes ☐ No

Has any patient listed ever applied to the Logan Health - Whitefish Community Financial Assistance program before?

☐ Yes ☐ No

If yes, what was the status?

☐ Approved ☐ Denied

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	____________	____________
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: ________________________ **Date:** ______________

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