

Dear Applicant,

Attached you will find an application for financial assistance.

It is important you fill out the form completely. Include all income for the household, including spouse, significant other, siblings, and any employed children or grandparents living with you.

To be considered, you must also apply for assistance at your local Department of Health and Human Services and provide us with a letter stating your determined eligibility.

Below is a list of everything we will need to determine your eligibility for financial assistance.

1. Complete financial assistance application
2. Copy of last year’s state or federal income tax return
3. Copy of most recent current year pay stub, Social Security check, or written statement from your employer verifying your current income
4. Copy of eligibly status from the Department of Health and Human Services for each applicant and dependents

Mail the completed application and other requirements within sixty (60) days to:

Logan Health - Conrad

Financial Assistance Processing

PO Box 668

Conrad MT 59425

Please do not submit original documents, other than the application. Once a determination has been made, you will receive a letter notifying you of the amount of assistance you are eligible for.

Sincerely,

Patient Financial Services

| Logan Health - Conrad & Logan Health Rural Health Clinic - Conrad**Financial assistance Application** |
| --- |
| Applicant Information |
| I am applying for Financial Assistance at [ ]  Logan Health [ ]  LOGAN HEALTH Clinic |
| Name: |
| Date of birth: | SSN: | Phone: |
| Current address: |
| City: | State: | Zip Code: |
| applicant Employment Information |
| Current employer: |
| Employer address: | Date of Hire: |
| Phone: | E-mail: | Fax: |
| City: | State: | Zip Code: |
| Position: | Rate: | Hrs/week: | Annual income: |
| Previous employer: | Leave Date: |
| Address: | Date of Hire: |
| Phone: | E-mail: | Fax: |
| City: | State: | Zip Code: |
| Position: | Rate: | Hrs/week: | Annual income: |
| Co-Applicant Information |
| Name: |
| Date of birth: | SSN: | Phone: |
| Current address: |
| City: | State: | Zip Code: |
| co-applicant Employment Information |
| Current employer: |
| Employer address: | Date of Hire: |
| Phone: | E-mail: | Fax: |
| City: | State: | Zip Code: |
| Position: | Rate:  | Hrs/week: | Annual income: |
| Previous employer:  | Leave Date: |
| Address: | Date of Hire: |
| Phone: | E-mail: | Fax: |
| City: | State: | Zip Code: |
| Position: | Rate: | Hrs/week: | Annual income: |
| dependents |
| Name | Social Security No | Date of Birth | Relationship |
| 1) |  |  |  |
| 2) |  |  |  |
| 3) |  |  |  |
| 4) |  |  |  |
| 5) |  |  |  |
| 6) |  |  |  |
| GROSS INCOME (as listed on Federal Tax Return) |
|  | Applicant | Co-Applicant | Other in Household |
| Total Income Last Year Source 1 |  |  |  |
| Total Income Last Year Source 2 |  |  |  |
| Projected Income This Year Source 1 |  |  |  |
| Projected Income This Year Source 2 |  |  |  |
| Other Income: |  |  |  |
| Assets |
| Primary Resident Value | $ |
| Other Real Estate Value | $ |
| Automobile Value | Make/Model: | $ |
| Recreational Vehicle Value | Make/Model: | $ |
| Investment Portfolio Value (stocks, bonds, cd’s) | $ |
| Other Assets | $ |
| Other Assets | $ |
| Checking Account Value | Bank: | $ |
| Savings Account Value | Bank: | $ |
| Other Bank Account Value | Bank: | $ |
| Other Bank Account Value | Bank: | $ |
| OTHER pERTINENT INFORMATION |
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| I state the information on this form is true and correct. I understand false or omitted information will result in disqualification of this application. I authorize Logan Health to verify this information and receive additional credit information as necessary.  |
| Signature of applicant | Date |
| Signature of co-applicant | Date |