EFFECTIVE - December 12, 2023

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 household income must be at or below 400% the Federal Poverty Income Guidelines. Federal Poverty Guidelines can be found at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

Discounts will be based on income and family / household size only. Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

Household as defined consists all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units (see next definition), but only one household. Logan Health Whitefish will also accept non-related household members when calculating family size.

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 online at www.logan.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

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

CCA-5
Rev. 12/2023
1 of 1

LOGAN HEALTH Whitefish

SOCSRV

Patient Name: _____ Pt. Account # _____

Responsible Party: _____ # of Dependents: _____

1. INCOME

Description	Monthly Income
A. GROSS SALARY	
Your	
Your Net Salary	
Employer	
B. GROSS SALARY	
Spouse (Optional)	
Net Salary - Spouse (Optional)	
Employer	
C. Dividend and Interest	
D. Rental Income	
E. Pension Income	
F. Self Emp. Income	
G. Social Security Benefits	
H. V.A. Benefits	
I. Welfare	
J. Child Support or Alimony	
K. Others - List	
L.	
M.	
N. Total Income per month	
O. Did you apply for the Affordable Care Act? ☐ Yes ☐ No	

2. EXPENSES

Description	Monthly Expenses
A. Rent or House Payment	
B. Food	
C. Utilities (Elect., Water, Etc.)	
D. Repairs (Car, Home)	
E. Installment Loans	
F.	
G. Car Payment	
H. Visa	
I. Master Card	
J. Sears	
K. Others - List	
L. Clothing	
M. Travel	
N. Education (college)	
O. Others - List	
P. Total Expenses per month	

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

Description	Value or Amount
A. Checking Account - Name of bank	
B. Savings Account - Name of bank	
C. IRA	
D. Insurance Policy (cash value)	
E. Home	
F. Car	
G. Others - List:	
H.	
I. Total Assets	

Approved By: _____

Date: _____

4. FOR OFFICE USE ONLY

Summary and Analysis Description	Amount
1. Total Income per month (line N)	
2. Total Expenses per month (line P)	
3. Excess Income per month (line 1-2)	
4. Patients Liability for hospital bill	

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

_____

Financial Counselor

I Certify the Above Information is True and Accurate.

_____

Patient Signature

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 not 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