LOGAN HEALTH

Financial Assistance Application

Date: _____

It is the policy of Logan Health Medical Center to provide essential services regardless of the patient's ability to pay. Logan Health offers discounts based on family size and annual income.

Please complete the following information and return to us to determine if you or your family members are elgible for a discount.

Patient Name	SSN (Optional)	Date of Birth
Address	City/State	Zip Code
Home Telephone	Work Telephone	Cell
Employer	Position	Date of Employment
Medical Insurance/Health Share		
E-mail		
Spouse/Significant Other Name	SSN (Optional)	Date of Birth
Employer	Position	Date of Employment
Name of Dependents(s) and DOB:		Total number of household members

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Patient Family Income: All resources (income) of the Patient's Family on an annual basis.

Monthly Income:	Yourself	Spouse/Significant Other
Employment/Gross Wages		
Social Security/Pension Income		
Public Assistance		
Unemployment Benefits		
Alimony/Child Support		
Worker's Compensation		
Any other sources of Income (describe)		
Total Monthly Income		

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Monthly Expenses: Optional

Rent or Mortgage Payment	$
Utilities	$
Telephone	$
Cable	$
Groceries	$
Prescriptions	$
Childcare	$
Child Support	$
Monthly Payment (Auto 1)	$
Monthly Payment (Auto 2)	$
Auto Insurance	$
Auto Maintenance/Gasoline	$
Health Insurance	$
Life Insurance	$
Other Loan payments	$
Total Payments on Credit Cards	$
Payments on Medical Bills	$
	$
	$
	$
Total Monthly Expenses	$

Financial Assistance Application

If you are not able to provide the information on this application please explain.

If you have no income, please explain how you meet your daily expenses.

Please provide any additional information about any other circumstances that you think will better help us to understand your situation.

Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Your signature authorizes Logan Health to verify information provided in this financial statement by obtaining a credit report and/or other financial information.

If you have any questions or are unable to provide complete information, please contact us at 406-752-1767.

Return application:
Logan Health
Attn: Financial Advising Dept.
310 Sunnyview Lane
Kalispell, MT 59901
Financial Advisors 406-752-1767
RFFinancialAdvisors@logan.org

Telephone Numbers:
Customer Service & Statement Questions
Please contact Patient Accounts at 406-609-0818

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