



805 Sunset Blvd • PO Box 668 • Conrad MT 59425
Ph (406) 271-3211 • Fx (406) 271-7446

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 eligibility 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			

