Sheridan Memorial Hospital Association
440 West Laurel Avenue
Plentywood, MT 59254
Phone: (406) 765-3700 Fax: (406) 765 3800

FINANCIAL ASSISTANCE PROGRAM

Sheridan Memorial Hospital is a not-for-profit hospital offering a broad range of services, which are provided with efficiency and sensitivity to the patient's need, both medically and financially. It is the policy of Sheridan Memorial Hospital to provide a reasonable amount medical service to eligible patients who cannot afford to pay for care. Your account balance may be adjusted if you qualify. Eligibility for free or discounted care is based upon the information you provide within this application. Please complete the entire form and include requested information.

Assistance is based on HOUSEHOLD income. Sheridan Memorial follows the Medicaid definition of household. Enclosed is a financial statement that we ask you to complete to help us determine your eligibility. Proof of income must be included with the financial statement when it is returned to the Patients Accounts Office. Proof of income must include AT LEAST TWO of the following:

1. Payroll check stubs or other monthly income sources for the last twelve (12) months. This means 12 months back from the date you apply for assistance.

2. W-2 Witholding statements for all employment during relevant period.

3. Employer signed and dated statement of income.

4. If Self-employed, a copy of your most recent Income Statement as well as your Year-to-Date Income Statement.

5. Copy of most recent completed IRS tax forms.

6. For those with NO EMPLOYMENT/INCOME to report please provide: Notice of eligibility/denial for unemployment or workers compensation benefits, Medicaid, SSI or SSDI etc.

7. Optional: Written statement explaining hardship and/or need.

8. Any other data requested which may be necessary to determine eligibility.

You have 240 days from date of service to apply for Financial Assistance. This application and accompanying proof of income must be returned to Sheridan Memorial within that time period. If application is received without required information you have 30 days to fulfill the request prior to denial. If additional time is required due to your medical condition, or if assistance with the financial statement is needed, contact the Financial Assistance Representative at (406) 765-3700. You will be notified in writing of the status of your Application within 90 days of receipt of complete documentation.

All information relating to application for the Financial Assistance Program will be kept confidential and will not be released to any third party without the consent of the applicant.

All applications and supporting documentation will be kept on file for 7 years from approval date. After 7 years documents will be disposed of in accordance to our Medical Records policy.

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FINANCIAL STATEMENT

1. Name _____ Date of Birth: _____

   Spouse's Name _____

   Address _____ _____
   Number & Street City State Zipcode

   Telephone _____

2. Occupation (self) _____ Employer Phone: _____

   Employer _____ _____ _____
   Name Hourly Wage Hours Worked Per Week

   Occupation (spouse) _____ Employer Phone: _____

   Employer _____ _____ _____
   Name Hourly Wage Hours Worked Per Week

   List Additional Occupations/Employers/Wages on another sheet if needed.

3. Number of Members Residing in Household (list ALL living with you please list first and last name).

Name	Relationship to Applicant	Date of Birth

4. Please list Name(s) of Patient(s) and Date(s) of service.

Patient Name	Patient Date of Service	Amount on Account

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5. Income: List all Income for **Household** during last twelve months.

Please place a "0" or "NA" in areas that do not apply to you. NO SPACE SHOULD BE LEFT BLANK.

Any type of income listed, please feel free to provide additional documentation for proof.

	Per Month		For Last 12 Months
Wages (Gross Income **before** taxes)			
Farm or Self Employment			
Public Assistance ___Food Stamps ___AFDC ___GA ___Other			
Social Security or SSI (include SS/SSI Annual Letter)			
Unemployment Compensation (include documentation)			
Worker's Compensation			
Alimony			
Child Support			
Pensions/Retirement			
Income from Dividends, Interest, Rent, etc.			
Income from sale of property			
Education grants/loans			
Inheritance			
Royalties			
Native American Income Monies			
Income Tax Refund ___Federal ___State			
Settlement Income ___Worker's Compensation ___Bodily Injury ___Lawsuit ___Other			
Other Income (please explain)			
TOTALS	$		$

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6. OPTIONAL:

   A written statement below explaining your hardship and/or need for assistance. Any additional information you are comfortable sharing that may assist you in receiving assistance and help us share other programs available to you.
   If you are unemployed, please state why here. If you do not receive unemployment benefits, please state why here.
   If you are receiving assistance from family, friends or other entities, please explain here.
   If additional space is needed please include a separate sheet of paper.

ACKNOWLEDGMENT

I certify that the above information is true and correct to the best of my knowledge. I understand that the information which I submit concerning my annual income and number of residents in my household is subject to verification by Sheridan Memorial Hospital Association. I understand that if the information which I submit is determined to be untrue, such a determination will result in denial of assistance, and that I will be liable for charges for the service provided.

I authorize a representative of Sheridan Memorial Hospital Association to obtain personal, financial or medical information from any source deemed necessary to determine my eligibility for financial assistance. In so authorizing, I release Sheridan Memorial Hospital Association and its representatives from any or all liability connected with said release.

Signature of Applicant _____ Date _____

Signature of Spouse _____ Date _____