

ShoCare

Affordable Healthcare

APPLICATION FORM

Patient Name:	Guarantor Name:
Physical Address:	Phone Number:

Are you a resident of Montana? Yes ___ No ___ If yes, for how long? ___ yrs ___ mo.

Insurance Information:

Do you or any other family member have health insurance? Yes ___ No ___

Were you an active recipient of Disability Assistance at the time of hospital service? Yes ___ No ___

If you answered "yes" to either question, please attach a copy of your card to this application.

Have you applied for Medicaid? Yes ___ No ___

If yes, what was the status of your application? Approved or Denied

Note: If you've been denied for Medicaid, please attach a copy of the Medicaid Denial to this application.

Patient Information: List the patient and each person who lives in the household below: * Please note that the family unit is defined to include the head of the household, their spouse, significant others, common law or same-sex partners, and any dependents living in the same household. **Dependent** means any of the following persons: the spouse or domestic partner; unmarried child(ren) for whom the guarantor claims an exemption on their federal tax return, and/or individuals under the employee's/spouse's health insurance policy

Name	Age	Relationship to Patient

Income (Proof of income MUST accompany this form)	Father or Head of Household	Mother or Spouse	Other Household Members
Gross pay per month \$ \$			
Monthly Child Support or Spousal Support received \$ \$			
Monthly Social Securities benefits received \$ \$			
Monthly Federal or State Program benefits received \$ \$			
Monthly Workers Comp or Unemployment benefits \$ \$			
Monthly Food Stamp allotment received \$ \$			
Other: \$ \$			
Total			

For timely processing of your request for ShoCare assistance, the following documents must be submitted along with this application:

- ___ A copy of your most current Federal Tax Return
- ___ A copy of your driver's license and a current utility bill

Please note: If any additional information is required, our Financial Resource Counselor will contact you by mail.

If you reported \$0 income, please attach a completed Letter of Financial Support and provide a brief explanation of how you (or the patient) are surviving financially:

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Assets	Account Balance
Savings or Credit Union or CD account balances \$	
Real Estate Home Equity (a-b) a) Home Value _____ less b) Mortgage Amount _____	
Checking account balance \$	
IRA's / Retirement Funds account balance \$	
Make & Model of vehicle(s)	
Other Assets (i.e. boats, RV's, snowmobiles, jet skis, quads, and other assets we should consider)	

I agree to apply for any available local, state, or federally funded health insurance programs for which any listed family member may qualify (e.g. SSI, Medicaid) within 60 days from the date of service.

My signature also authorizes the release of my credit information to Shodair Children's Hospital for the purpose of reviewing my ShoCare application.

Return this form with any attachments to:

Shodair Children's Hospital
Attn: Financial Resource Counselor
P.O. Box 5539
Helena, MT 59604
(406) 444-7500

Explain any unusual circumstances that you think should be considered:

By my signature, I certify that everything I have stated on this application and/or any attachments is correct.

Applicant's Signature

Shodair Children's Hospital
LETTER OF FINANCIAL SUPPORT

Shodair Children's Hospital

Appendix C

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Patient Name: _____ Patient SSN# _____

This is to certify that I, _____,
(Supporter) (Relationship)
of patient, _____, does live/does not live with me and/but I
provide him/her with financial support. I have done so for _____ months/years:

- () I provide free room and board to the above individual.
- () I provide the above individual with \$ _____ a week/month.
- () I have provided a personal loan to the above individual in the amount of \$ _____
on _____.
(Date)

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this application.

I also understand that a credit report may be obtained or other such measures may be taken to verify the information provided herein.

Signature of Supporter

Date _____