ShoCare Application Form

Effective January 1, 2018

SHOCARE
Shodair Children's Hospital

Patient Name: _____ **Account #s (if applicable)** _____

2017 FPL	Family Size	A (100% Discount) Income Level From	A To *	B (60% Discount) Income Level From	B To	C (40% Discount) Income Level From	C To	F (20% Discount) Income Level From	F To
$12,060	1	$0	$24,120	$24,121	$36,180	$36,181	$48,240	$48,241	& Up
$16,240	2	$0	$32,480	$32,481	$48,720	$48,721	$64,960	$64,961	& Up
$20,420	3	$0	$40,840	$40,841	$61,260	$61,261	$81,680	$81,681	& Up
$24,600	4	$0	$49,200	$49,201	$73,800	$73,801	$98,400	$98,401	& Up
$28,780	5	$0	$57,560	$57,561	$86,340	$86,341	$115,120	$115,121	& Up
$32,960	6	$0	$65,920	$65,921	$98,880	$98,881	$131,840	$131,841	& Up
$37,140	7	$0	$74,280	$74,281	$111,420	$111,421	$148,560	$148,561	& Up
$41,320	8	$0	$82,640	$82,641	$123,960	$123,961	$165,280	$165,281	& Up
	% Poverty Level	0% - 200%		201-300%		301-400%			

ShoCare was created for Montana residents who have lived in Montana for at least three (3) months prior to receiving services.

Shodair
CHILDREN'S HOSPITAL

* Income is defined to include all sources of household income including but not limited to: gross wages, social security, governmental assistance, child support,alimony, unemployment compensation and business and investment income.

*** Shodair will also consider how much other medical debt you owe in determining your ShoCare discount. Please indicated how much other medical debt you owe, not including your current account with Shodair: $_____**

By circling your income range on the table above and signing your name below, you attest that the you have provided true and verifyable income information and are willing to provide written proof of income if requested by Shodair.

_____ _____
Name (person responsible for bill) **Date**

_____ **Shodair Approvals:** _____ **Dept/Staff Sponsor**
Signature _____ **Percent Approved by CFO**
_____ **Date Approved/CFO initials**
_____ **Account(s) approved**