



2755 Colonial Drive
 PO Box 5539
 Helena, MT 59604

ShoCare Patient Financial Assistance Sliding Discount Application

It is the policy of Shodair Children’s Hospital to provide essential services regardless of the patient or their guarantors ability to pay. Discounts are offer based on family size and annual income. Please complete the following information and return it in-person or by mail to determine if you are eligible for a discount.

Please complete the following:

Head of Household (as filed on tax returns)	Place of Employment
Street Address (city, state, and zip code)	Mailing Address (city, state, and zip code)
Home Telephone #	Cell Phone #

Please list your spouse (if applicable) and any dependents under the age of 18.

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, Veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, alimony, child support, and other miscellaneous sources				
Total Income				

NOTE: Income is defined to include all of the sources listed in the table above. Shodair may require copies of tax returns, pay stubs, or other information verifying income before a discount is approved.

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

By signing your name below you attest that the information provided on this form including family size and annual income is true and verifiable, and you are willing to provide proof of this information at any time if/when request by Shodair.

Name (Print): _____

Signature: _____

Date: _____

Office use only

Applicant Name: _____

Approved Discount: _____

Approved By: _____

Date Approved: _____

Date Added to Account in EPIC: _____