STEELE MEMORIAL MEDICAL CENTER
203 S. Daisy Street
Salmon, Idaho 83467

Dear Patient,

Thank you for utilizing Steele Memorial Medical Center for your medical services. In reviewing your account(s), you may be eligible for financial assistance offered through Steele Memorial Medical Center.

Enclosed you will find a financial statement. Please complete and return to the above address (Attention: Patient Financial Services) with copies of your most recent:

- Bank statement – Last two, most current and complete
- W-2's and/or Social Security statement (Form 1099 received at beginning of year)
- Last year's tax return (if applicable)
- Pay stubs – Last two current
- Letter from Medicaid (denial or acceptance)
- Copies of Driver's License for 18 and over

Once we have received all of the above information your account will be reviewed by administration.

You can return the required documents:

- 203 S. Daisy Street – Attention Patient Financial
- Fax – 208-756-4169
- Drop off at the front desk of the main hospital (patient registration)

Please only send in copies of your documents, no originals.

STEELE MEMORIAL MEDICAL CENTER

Patient Financial Services Policy

Title: 600-023 Charity Policy Attachment A

Originating Date: 08/09/2018 **Last Reviewed:** 12/21/2023

Steele Memorial Medical Center
203 S Daisy St.
Salmon, ID 83467
Phone: (208) 756-5600

FINANCIAL STATEMENT

1. Head of Household: _____ Spouse's Name: _____

   Address: _____

   Home Phone: _____ Work Phone: _____

2. Occupation (SELF): _____ Social Security # (optional): _____

   Employer (SELF): _____

   Employer Address: _____

   Occupation (SPOUSE): _____ Social Security # (optional): _____

   Employer (SPOUSE): _____

   Employer Address: _____

3. Number of members residing in household (FIRST AND LAST NAMES):

Name	Relationship	Age

4. Income - List all income for household:

	Monthly	Yearly
Wages (Gross – before taxes):		
Farm or Self-employment:		
Public Assistance:		
Social Security/or SSI:		
Unemployment Compensation:		
Worker's Compensation:		
Strike Benefits:		
Alimony:		
Child Support:		
Military Family Allotments:		
Pensions/Retirement:		
Dividends, Interest, Rent, ETC.		
Sale of Property:		
Education Grants/ Loans:		
Inheritance:		
Royalties:		
Native American Income:		
Income Tax Refund ___FED ___STATE		
Settlement Income:		

3. Monthly Expenses The information below is not required for patients seeking care in the Out Patient Clinic or ER.

5.

Rent: $_____ Gasoline: $_____ Food: $_____

Insurance(s): $_____ Electric: $_____ Childcare: $_____

Heating Fuel: $_____ Child Support: $_____ Phone: $_____

Pharmacy: $_____ Water: $_____ Alimony: $_____

Cable TV: $_____

TOTAL EXPENSES: $_____

4. Liabilities (I owe) The information below is not required for patients seeking care in the Out Patient Clinic or ER.

6.

	List Names	Current Balance	Payment
Bank/Credit Union:	_____	$_____	$_____
	_____	$_____	$_____
	_____	$_____	$_____
Mortgage Loan:	_____	$_____	$_____
	_____	$_____	$_____
	_____	$_____	$_____
Auto/RV Loan:	_____	$_____	$_____
	_____	$_____	$_____
Credit cards/Revolving Acct.:	_____	$_____	$_____
	_____	$_____	$_____
	_____	$_____	$_____
Medical/Hospital Bills:	_____	$_____	$_____
	_____	$_____	$_____
	_____	$_____	$_____
Medical/Hospital Bills: (including dentists)	_____	$_____	$_____
	_____	$_____	$_____
	_____	$_____	$_____
Collection Agency Accounts:	_____	$_____	$_____
	_____	$_____	$_____
	_____	$_____	$_____
School Loans:	_____	$_____	$_____
Other:	_____	$_____	$_____
Total Liabilities:		$_____	

Total Monthly Payments: $_____

7. Additional circumstances or reasons for requesting charity from the hospital or clinic.

_____

_____

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_____

Signature: _____ Date: _____

Signature (Spouse): _____ Date: _____