SOUTHWEST MONTANA COMMUNITY HEALTH CENTER (SWMTCHC)

Income Verification and Sliding Fee Discount Program Application

Responsible Party _____ DOB _____

SSN _____ Phone _____

Address _____ City, State, Zip _____

Family/Household size _____ Annual Gross Household Income $ _____

FAMILY (HOUSEHOLD) SIZE: Please count all the people in your household for whom you are financially and/or legally responsible and are related by blood, marriage, adoption, or other legally binding situation.

ANNUAL HOUSEHOLD INCOME: Please include all total gross income (amount before taxes) for the members of the household.

Proof of at least one month's worth of household income is required when applying for a sliding fee discount. Any changes in income or household size need to be reported to our clinic. If no proof is received, the sliding fee discount expires in 30 days (grace period). **Two grace periods are allowed in a lifetime.**

SWMTCHC offers a sliding fee discount program to all who qualify. To be eligible, the patient must have household income below 200% of the Federal Poverty Level (FPL), which is based on pre-tax income and size of household. We request income information from all of our patients, regardless of eligibility/participation. It is used to calculate sliding fee discounts and to report summary information for our grant, which allows us to offer these discounts.

The sliding fee discount applies to services provided; medications, labs, & equipment DO NOT qualify, but are offered at reduced rates.

PLEASE CHECK <u>ONE</u> OF THE FOLLOWING OPTIONS (INCOME/FAMILY SIZE REQUIRED IF YOU WISH TO PARTICIPATE)

- ☐ I wish to participate in the sliding fee program, but I do not have proof of income with me today.
  - ○ I want to use 1 of my 2 LIFETIME TOTAL allowed grace periods. I understand that if I do not submit proof of income within 30 days, I forfeit my grace period.
  - ○ I do NOT want to use a grace period.
- ☐ I wish to participate in the sliding fee program, and I have proof of income with me today.
- ☐ My income is above the sliding fee range, but I wish to submit proof of income for possible Medication Assistance at SWMTCHC pharmacies. INCOME AND FAMILY SIZE REQUIRED
- ☐ I **<u>do not</u>** wish to participate in the sliding fee program/refuse application.

I fully understand that I must submit complete information for all household income. I understand that a person who obtains or attempts to obtain services or discounts to which they are not entitled may be prosecuted under applicable State and Federal law.

_____ _____

Signature Date

Staff Use Only:

Income: Fam size: Staff initials:

Status: Reason: Proof of income:

Guarantor: DOB: Proof Provided Yes ☐ No ☐

NOTES:

Date Received