Southwest Montana Community Health Center
Income Verification and Sliding Fee Discount Form 2021

The Southwest Montana Community Health Center (SWMTCHC) offers a sliding fee discount program to anyone who qualifies. To qualify, the patient must have household income below 200% of the Federal Poverty Level (FPL), which is based on both household income and size. We also request income information for those who don't qualify or don't want to participate in the sliding fee discount program. Providing this information is voluntary and it will be kept confidential. Please check on of the following options:

☐	I **do not** wish to participate in the sliding fee program.
☐	I wish to participate in the sliding fee program, but I don't have proof of income with me today.
☐	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.

Patient Name_____ Date of Birth_____

SSN_____ Address_____

Phone_____ City,State,Zip_____

Responsible party name, SSN, DOB and phone if not patient_____

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HOUSEHOLD INFORMATION: Please list all the people in your household related by blood, marriage, or adoption, who are financially legally responsible for each other. (If needed, please list additional members on back of form.)

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT

Circle your appropriate income and family size range. Please complete even if not applying for discount.*

House hold Size	Annual Household Income Range											
	From	To	From	To	From	To	From	To	From	To	From	To
1	$0 -	12,880	12,881 -	16,100	16,101 -	19,320	19,321 -	22,540	22,541 -	25,760	25,761	and over
2	$0 -	17,420	17,421 -	21,775	21,776 -	26,130	26,131 -	30,485	30,486 -	34,840	34,841	and over
3	$0 -	21,960	21,961 -	27,450	27,451 -	32,940	32,941 -	38,430	38,431 -	43,920	43,921	and over
4	$0 -	26,500	26,501 -	33,125	33,126 -	39,750	39,751 -	46,375	46,376 -	53,000	53,001	and over
5	$0 -	31,040	31,041 -	38,800	38,801 -	46,560	46,561 -	54,320	54,321 -	62,080	62,081	and over
6	$0 -	35,580	35,581 -	44,475	44,476 -	53,370	53,371 -	62,265	62,266 -	71,160	71,161	and over
7	$0 -	40,120	40,121 -	50,150	50,151 -	60,180	60,181 -	70,210	70,211 -	80,240	80,241	and over
8	$0 -	44,660	44,661 -	55,825	55,826 -	66,990	66,991 -	78,155	78,156 -	89,320	89,321	and over

* Income information is kept confidential and only used to calculate sliding fee discounts and to report summary information for our grant, which allows us to offer these discounts.

If applying for a sliding fee discount, please furnish all forms of income for proof of eligibility for sliding fee discount program. Verification is required and can include most recent tax return, paycheck stubs for one month, Social Security letter, unemployment letter, alimony, veteran's benefits, etc. Sliding fee eligibility is updated annually and changes in income or circumstances should be reported to our clinic. **If no proof is given, the sliding fee discount expires in 30 days and only two such self declarations are allowed in a lifetime.**

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 & Federal law.

The discount applies to services provided. Medications, labs, & equipment **do not** qualify for slide, but are offered at reduced rates.

Signature & Date_____ Staff Signature & Date_____

Staff Use Only:

Guarantor Account#_____ Proof of Income_____ Proof Provided YES ☐ NO ☐

Reason_____ Total Annual Income_____

Household Size_____Status_____ % Patient Owes_____Expires_____