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

Patient Name_____ Date of Birth_____

SSN_____ Phone_____

Address_____ City,State,Zip_____

Household size_____ Annual Household Income $_____

HOUSEHOLD INFORMATION: We would like to extend the discount to all eligible family members. Please list all the people in your household who are financially legally responsible for each other and are related by blood, marriage, adoption, or other legally binding situation.

Name	DOB	Relationship to applicant

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.

Proof of a 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.

Please check one of the following options:

☐	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.
☐	I **do not** wish to participate in the sliding fee program.

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.

Signature_____ Date_____

Staff Use Only: Verbal ☐ MyChart ☐ Patient ☐

Guarantor Account#(s)_____ Staff initials_____ Proof Provided YES ☐ NO ☐

Income $_____ Fam Size_____ Reason_____ Status_____

Southwest Montana Community Health Center
Sliding Fee Schedule - Effective February 1, 2021
Based on Federal Poverty Guidelines (FPG) guidelines published January 18, 2021

Family Size	A Nominal Fee FPG <= 100% From	To	B 80% Discount Pay 20% FPG 101%-125% From	To	C 65% Discount Pay 35% FPG 126%-150% From	To	D 50% Discount Pay 50% FPG 151%-175% From	To	E 35% Discount Pay 65% FPG 176%-200% From	To	F No Discount Pay 100% FPG > 200% 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
9	$0	$49,200	$49,201	$61,500	$61,501	$73,800	$73,801	$86,100	$86,101	$98,400	$98,401	And over
10	$0	$53,740	$53,741	$67,175	$67,176	$80,610	$80,611	$94,045	$94,046	$107,480	$107,481	And over

All people will have access to health care regardless of their ability to pay. Please let us know how we can assist you.

Each Column represents the annual household income.

SWMTCHC Nominal Fee is column A

Medical nominal fee is $20.00

Behavioral Health nominal fee is $10.00

Dental nominal fee is $40.00 *

When patient falls into column B, C, D, E, they receive a discount of 80, 65, 50, or 35% off of the full charge in each of the corresponding categories.* The charges for patients in categories B,C,D,E will not be discounted below the nominal fee.

Patient pays 100% of the full charges if they are in column F. We can set up a payment plan for any patient who requests one.

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

* Major Dental Procedures may include an additional Lab Charge.