SFS WORKSHEET FORM (We will not honor Slides without Proof of Income)

Patient Name _____ **DOB** _____ **PT #** _____

■ I am applying for a Sliding Fee discount and must meet the following rules to be eligible:

- I must make a minimum payment of **$10.00 Medical - $50.00 Dental - $10 LAC** each visit at the time of service. If I am unable to pay my entire portion of the bill, I will sign a Payment Plan at the time of service and make monthly payments.
- I must give proof of the total household income to the Bullhook Community Health Center every twelve months and/or if there is a change of status in my income source before the twelve months.
- If I have any health insurance, Medicaid, or Medicare, I must give that information to the intake staff now. If at any time in the future I receive private health insurance, Montana Healthy Kids, Medicaid, or Medicare, I must give that information to the intake staff at the time of service.
- **I understand that I am required to provide my income verification at the time of service to determine the level of sliding fee services I qualify for**.

YOU AND YOUR HOUSEHOLD MEMBERS INFORMATION:

Last Name, First Name, Middle	Relationship	Birth Date	SSN	Sex	Ethnic Group	Insurance

FINANCIAL STATUS WORKSHEET

VERIFY ALL SOURCES OF GROSS INCOME (PROOF OF INCOME IS NECESSARY TO QUALIFY FOR SLIDING FEE)

HOUSEHOLD INCOME	Amount	Weekly, Every other week, Twice a Month, Monthly, Annually
Wages Gross		
Self Employment		
Unemployment		
Workers Compensation		
Retirement/Pension		
Social Security		
Disability		
Alimony or Maintenance		
Other (please indicate)		

Office Use Only:

$ _____X _____ =

$ _____X _____ =

$ _____X _____ =

$_____ Income

Circle One:

Annual Weekly Monthly

Signed _____ **Date** _____

Expires one year from this date

For Office Use Only:

TOTAL GROSS INCOME: _____**FAMILY SIZE** _____

FOR BCHC USE: STAFF INITIALS **DATE:** **SLIDING SCALE: A B C D E NONE**

Bullhook Community Health Center, Inc.
"Partners in Healthy Living"