BULLHOOK Community Health Center **Sliding Fee Discount Worksheet (We will not honor your discount without proof of income)**

Patient Name: _____ Patient DOB: _____

☐ **Yes –** I have received information on Bullhook Community Health Center's sliding fee discount program and I would like to apply for this discount. I will complete the section below and provide proof of income for every working member of my household within 24 hours.

To start your application, fill in the fields below for each member of your house hold.

Full Name	Date of Birth	Relationship to you	SSN	Employed?
		SELF		☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

☐ Yes ☐ No I have attached my proof on income as follows:

☐ Tax Return ☐ Current one-month wage stubs ☐ Paperwork from OPA office ☐ A letter on employer's letter head stating current monthly wages ☐ Self-attestation letter signed by adult

If No, Explain why: _____

_____

- **I must make a minimum payment depending on the department visit as follows Medical - $10.00; Dental - $50.00; Behavioral Health Services - $10.00.**
- **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 are up.**
- **If I have any health insurance, Medicaid or Medicare I must give that information to the front staff now. If at any time in the future I receive private health insurance, Montana Health Kids, Medicaid or Medicare I must give that information to the front 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 discount I qualify for.**

I certify by signing this document that all the above statements are true and will follow Bullhook Community Health Center payment requirements.

_____ _____

Signature of Patient or guardian Date (This discount expires one year from this date)

FOR OFFICE USE ONLY

$ _____ X _____ = _____

$ _____ X _____ = _____

$ _____ X _____ = _____

$ _____ X _____ = _____

TOTAL GROSS INCOME $ _____

FAMILY SIZE: _____

ESTIMATED Slide Level A B C D E OVER INCOME

Staff Signature: _____ Date: _____

Location: Shared > FORMS > Front Desk > Patient Intake forms > SFS APPLICATION FORMS > SFS Worksheet application