



B u s O f f i c e D o c



COMMUNITY
HEALTH PARTNERS

REAL PEOPLE. REMARKABLE HEALTHCARE.
112 W Lewis St, Livingston, MT 59047

Sliding Fee (Discount) Eligibility

Your household income should be updated:

- > Every 3 months if you have no documentation of income due to unemployment/homelessness
- > Every 12 months if documentation of income is not your personal tax return
- > As soon as filed, but no later than Nov 1 of the next year when providing your tax return information

Total number of people in your household who you share expenses with including yourself, spouse, boyfriend, girlfriend, partner, other family members, and all children _____

	Legal Name	Employed	Male Female	Birth Date	CHP Patient	Relationship
1		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	Self
2		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
3		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
4		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
5		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	

List everyone in your household who is employed, including spouse, boyfriend, girlfriend, partner and children 18 years of age and older:

Name	Employer	Gross Monthly Income
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any other monthly income for your household (including Children SSI, TANF and SS Death Benefits):

Social Security \$ _____	Workers Comp/Disability \$ _____	Other Income \$ _____
Veterans \$ _____	Alimony/Child Support \$ _____	I am unemployed _____
Unemployment \$ _____	Interest/Dividend Income \$ _____	I have no income _____
TANF \$ _____	Self Employment \$ _____	

Do you pay child support and/or alimony? _____ If documented, we will deduct this from your income when calculating your slide.

All information on this form is a true statement of income at this time. If I give false information, I may be prosecuted under state and federal laws. I agree to report any changes within 30 days of the change.

Signature _____

Date _____

Complete Address: Number & Street (or P.O.Box), City, State, Zip _____

Phone Number _____

Please complete, attach documentation of all income, and return within 30 days of visit

For Office use only:

Weekly: Total of all checks: \$ _____ Divide by 3= \$ _____ x 52 \$ _____ yearly total \$ _____	Bi-monthly (pd twice/month on set days): Total of all checks: \$ _____ Divide by 3= \$ _____ x 24 \$ _____ yearly total \$ _____	Yearly (gross) \$ _____ SSI/Retirement: Gross before Medicare Deduction: Gross/month x 12 \$ _____
Bi-Weekly (pd every 2 weeks): \$ _____ Divide by 3= \$ _____ x 26 \$ _____ yearly total	Self Statement of Gross Monthly Income: \$ _____ x 12 \$ _____ yearly total	Slide: _____ Start Date: _____ End Date: _____

Tax Returns:

For sliding fee applications we only accept individual tax returns which will normally be **Form 1040**

For Tax Years 2020 and 2021, please request page 1.

	Tax Year 2020 (exp 11/1/22)	Tax Year 2021 (exp 11/1/23)
Adjusted Gross Income	\$ _____ Page 1, Line 11	\$ _____ Page 1, Line 11
Plus Untaxed Social Security	\$ _____ Page 1: 6a minus 6b	\$ _____ Page 1: 6a minus 6b
Plus Yearly amounts of (per month x 12):		
\$ _____	Child Support	\$ _____
\$ _____	VA Disability	\$ _____
\$ _____	Workers Comp Income	\$ _____
\$ _____	TANF	\$ _____
\$ _____	= Total Yearly Income	\$ _____

Calculation of Household Income:

Total yearly income	\$ _____
Less Annual Child Support Paid	\$ _____ (3 payments documented)
Less Annual Alimony Paid (if tax return not provided)	\$ _____ (3 payments documented)
Annual Household Income	\$ _____

Entered into F/P	Initials: _____
Entered into All Family Members	Initials: _____
Entered into Dental Guarantor	Initials: _____
Double checked: Math F/P Family Dental	Initials: _____



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SCAN: E Label
Doc Desc: CHP Sliding Scale