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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		□ Yes □ No			□ Yes □ No	Self
2		□ Yes □ No			□ Yes □ No	
3		□ Yes □ No			□ Yes □ No	
4		□ Yes □ No			□ Yes □ No	
5		□ Yes □ No			□ Yes □ 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 2019 and 2020, please request page 1.

	Tax Year 2019 (exp 11/1/21)		**Tax Year 2020 (exp 11/1/22)**
Adjusted Gross Income	$_____ Page 1, Line 8b		$_____ Page 1, Line 11
Plus Untaxed Social Security	$_____ Page 1: 5a minus 5b		$_____ 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: _____