Glacier Community Health Center
Application for Sliding Fee Program

Please complete the following:

Current
Mailing Address: _____

_____

Phone #: _____

- **List your household members** AND full dates of birth.
- **Provide current gross income** for the entire household.
- **Supply proof of income** for everyone in the household from one or more of the following:
  - Current year 1040 tax form (include sched C or F for farming/self employed)
  - **Paycheck stubs** for one full, recent month (preferably with year to date income provided)
  - Office of Public Assistance benefit printout for **TANF income,** any **Alimony award***(not child support, not SNAP)*
  - Benefits for **Enrolled Tribal Members**
  - **Social Security** – Current year award letter from Social Security ***(no bank statements)***
  - **Ranch hands** – if housing is provided, please note the value of rent and utilities that employer pays for
  - **Tip Earners**: Enter the weekly amount you earn in **tips** **HERE: $_____**

#	First & Last Names	Relation-ship	Birth Date	Gross (before taxes) Household Income	Average # Hours Worked Each Week	Type of Income Choose from the following: ▪ Earned Wages ▪ Self-Employment ▪ Un-employment ▪ TANF ▪ Disability ▪ Social Security ▪ Alimony ▪ Other	Is this year-round employment?	I get paid on this schedule
1	Please print neatly	SELF		$			☐ Yes ☐ No If no, how many months? _____	☐ Weekly ☐ Every other wk ☐ 1st & 15th ☐ Monthly ☐ Other
2				$			☐ Yes ☐ No If no, how many months? _____	☐ Weekly ☐ Every other wk ☐ 1st & 16th ☐ Monthly ☐ Other
3								
4								
5								
6								
7								
8								

Total Number of Household Members: _____

Are you eligible to receive services at IHS? Yes____ No____

This information is true and accurate to the best of my knowledge, under penalty of perjury.

If you are attesting to having NO INCOME, also complete page 2. Otherwise, do not.

Signed _____ **Date**_____

OFFICE USE ONLY

___Scanned
___SF/Ins updated
___Action to Dental/Medical
___Action to renew
___Letter
_____Audited Med
_____Audited Dental

Total Income: $ _____

Sliding Fee Scale
A B C D E
Over Income

Staff Init: _____ Date: _____
___Renewal
___Change to current
___New Applicant
SF Starts: _____
SF Ends: _____

ATTESTATION OF "NO INCOME" PAGE

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IGNORE THIS PAGE IF YOU HAVE INCOME TO REPORT.

This page is only for those attesting to NO income for the entire household at this time.

Please Print Your Name: _____

Have you been on GCHC's sliding fee before? ☐ YES ☐ NO

If NO, sign page 1 and initial here_____. Skip the rest of the page.

If YES, did you sign that you had zero income? ☐ YES ☐ NO

IF NO, sign page 1 and initial here_____. Skip the rest of the page.

If YES, please tell us a bit about your living situation. Circle all that apply to the household:

SNAP
LIEAP (energy assistance)
Income based housing
Food Bank
WIC
Other:_____

Please take a moment to describe how you are getting by:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you. You will be notified by mail when your application has been fully processed or if more information is needed to complete your sliding fee application.

Glacier Community Health Center, Inc
406-873-5670
Fax 873-2256