**Glacier Community Health Center**

Current

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Application for Sliding Fee Program**

Please complete the following:

* **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 F for farming if applicable)
  + **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** |  |  |  |  |  |  |  |  |

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

**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.

**Signed** **Date**

**OFFICE USE ONLY**

Staff Init: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Total Income: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Renewal

\_\_\_Scanned

Sliding Fee Scale

A B C D E

Over Income

\_\_\_Change to current

SF Starts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Letter

\_\_\_\_\_\_Audited Med

\_\_\_\_\_\_Audited Dental

\_\_\_New Applicant

SF Ends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Action to Dental/Medical

\_\_\_Action to renew

\_\_\_SF/Ins updated

**ATTESTATION OF “NO INCOME” PAGE**

**Glacier Community Health Center**

**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.**

**Application for Sliding Fee Program**

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