DISCOUNTED/SLIDING FEE APPLICATION

It is the policy of Northeast Montana Health Services', Inc. subsidiary clinics to provide essential services regardless of the patient's ability to pay. Discounts are offered will be set at 200% of the federal poverty guidelines as set forth by the Department of Health & Human Services. Discounts will be offered based on family income and size. Please complete the following information and return to either the Business Office or the clinic receptionist to determine if you are eligible for a discount.

The discount will apply to all services received at this clinic with the exception of cosmetic services. Services which are purchased from outside the clinic including laboratory, reference laboratory, radiology, pharmacy and other services are excluded. In the hope that your financial situation improves, discounts only apply to current, not future services.

You must apply for Medicaid, or SCHIPS and be denied before discounted services will apply. A written letter of denial must be available.

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Number of related persons living in your household: ☐

Have you applied and been denied Medicaid, SS disability or SCHIPS: ☐ yes ☐ no

HOUSEHOLD MEMBERS	HOUSEHOLD INCOME (COMPLETE ONE COLUMN)		
	Annual	Monthly	Bi-Weekly
SELF			
SPOUSE			
Dependent Children Under age 18			
TOTAL			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans payments, alimony, child support, military, unemployment and public assistance.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) ______________________________ Date: ________________

Signature ______________________________

Office Use Only

Patient name ☐ Discount ☐

Date of Service ☐ Approved By ☐