SLIDING FEE FINANCIAL ASSISTANCE PROGRAM APPLICATION

It is the policy of Western Montana Health Center to provide appropriate services to all clients regardless of their ability to pay. Financial Assistance and Discounts are offered based on family size and gross annual income. Please complete the following information and return to Western Montana Mental Health Center to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic excluding any services that are court-mandated. The discount will not apply to balances on services that you elect not to have billed to my insurance carrier. The discount will be applied to all eligible outstanding balances on your account for a period of six (6) months prior to and for a period of 12 months after the application is approved. If your financial situation changes, or at the end of 12 months, you will be asked to complete a new application for a continued Discount.

Client Name: _____

If Minor, Parent or Guardian Name: _____

HOUSEHOLD INFORMATION

Include information about everyone who lives with you, starting with yourself on the first line.

Name (example: Doe, John A.)	Relationship	Date of Birth	Marital Status	MT Resident
	SELF			

INCOME FROM EMPLOYMENT AND OTHER SOURCES

List all earned and unearned income received by all household members, including children. Unearned income includes, but is not limited to, Social Security Disability (SSD), Unemployment Insurance, Child Support, Pensions, Military Allotments, Alimony, Lease or Rental Income, Supplemental Security Income (SSI), Foster Care Payments, Veteran's Benefits, Retirement Income, Tribal Assistance Payment, Dividends, Interest, Temporary Disability, TANF, and Student Loans.

Attach proof of income for all items listed as income received.

Name of Household Member	Type/Source of Income	How Often is Income Received? (weekly, bi-weekly, monthly, semi-monthly, annually)	Amount Received

RESPONSIBLE PARTY FOR PAYMENT

Complete only if different from Client Information or client is a minor.

Name of person responsible:_____ Relationship to Client: _____

Mailing Address: _____
Street Address/P.O. Box City State Zip

Phone Number (Home):_____ (Work): _____

ACKNOWLEDGEMENT

I certify that the information included in this application is correct and has not been falsified.

Name (Please Print): _____ Relationship to Client: _____

Signature: _____ Date: _____

OFFICE USE ONLY

Client Name: _____ Account # : _____

Approved Discount: _____

Reviewed by: _____ Approved by: _____

Date Approved: _____ Expiration Date: _____

Outstanding Balance on the Account: _____

Adjusted Balance on Account after Discount: _____

Date Notification Was Sent to Client: _____