Partnership Health Center
Sliding Fee Scale/Nominal Fee Eligibility Documentation
PHCFORM2 REVISED 07/31/15

Partnership Health Center
Missoula's Community Health Center

Date of Application: _____ New Patient: **Yes / No**
(circle one)

Patient Name: _____ Patient Date of Birth: _____

Patient Age: _____ Patient SSN: _____

Guardian Name: _____ Guardian SSN: _____
(if patient is under 18)

It is the policy of Partnership Health Center (PHC) to provide affordable health care services to all our patients. PHC must know and document how much money patients earn in order to provide health care services at an appropriate rate based on our Sliding Fee Discount Schedule. This information may also help PHC to assist patients with other programs that offer financial assistance or benefits. If you have any questions about this form, please ask a Receptionist or an Eligibility Technician. Thank you.

To be completed by Patient or Guardian

Do you have any type of insurance that will cover all or a portion of your medical expenses? **Yes / No**

If yes, please list: _____

HOUSEHOLD MEMBER INFORMATION (please print):					
Full Name	**Relationship to You**	**Date of Birth**	**SSN**	***Estimated* Annual Income**	**Insurance**
	Self				

I understand that I need to present proof of my income before the Sliding Fee Discount will be applied to my account.
I declare that the information I have supplied is correct and complete to the best of my knowledge. I give PHC permission to investigate any information given on this application. I also understand that if my income should change, I am required to notify a Receptionist or Eligibility Technician.

Signature: _____ Date: _____

Legal Guardian must sign if under 18 years of age

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Questions? Call (406) 258-4450

Or inquire at the front desk with any of our Receptionists or Eligibility Technicians.

What information do you need to bring to prove your income?

See the list in the table below called 'Income Type/Document'.

How long do you have to return your proof of income with this completed form?

Please return no later than 5 business days after your appointment.

What is a 'household'?

A 'household' can be defined as the number of people living together sharing financial responsibility.

Example #1: A family of 4 (2 parents & 2 children) would be a household size of 4. We will need proof of income from any and all of these 4 household members who contribute income to the household.

Example #2: A group of young adults share rental expenses for a house, but do not share responsibility for other personal expenses. You are a member of this household and have no children. Your household size is 1. We will only need proof of your personal income.

Can't make it in to submit your proof of income?

You may send your proof of income with this completed form to our office.

Per mail: **401 Railroad St. W, Missoula MT, 59802**
Per fax: **(406) 258-4732.**

Are you interested in purchasing Insurance?

We have Certified Application Counselors who can answer any questions you may have about the Insurance Marketplace. We are able to help make an account on-line, or assist you in filling out your paper application. Call (406) 258-4450.

****Do not write below this line. To be completed by PHC Employee.****

Income Type/Document	Income Amount	Copies Provided
1040 Tax Form for the most recent calendar year		
One month of consecutive pay stubs (if no tax return filed in past year)		
Social Security Letter		
Food stamps benefit history (CHIMES Report)		
Pension Letter		
Grant letter – *Students Only*		
Patient self-declaration – *income statement with patient signature. Must be witnessed and signed by a PHC staff member.*		
Other:		

Sliding Fee Scale (A, B, C, D, E, None)	Slide Effective Date	Slide Termination Date

Signature of PHC Employee *Printed Name* *Date*