SLIDING FEE DISCOUNT PROGRAM

As a Federally Qualified Healthcare Center, Sapphire Community Health can offer most services on a sliding fee schedule. This means, depending on your household income and family size, you may qualify for discounts on your healthcare costs.

Sliding Fee Program Eligibility

Sapphire Community Health staff are available to assist patients in determining their eligibility for discounts through this program. Sapphire Community Health uses the current Federal Poverty Guidelines to determine the discount available. You will find the most current schedule and application attached.

How to apply for the Sliding Fee Program

Please complete the attached application and return it to Sapphire Community Health. Eligibility will be based on review of the application and the additional supporting documentation required. We will contact you regarding your eligibility.

- ***Household Size****: All people who live in your household related by blood, marriage, and/or adoption.*
- ***Dependents****: Children under the age of 19 or (24 if a full-time student) that are related by blood, legal adoption, and/or legally disabled adults may be considered dependents.*
- ***Income****: ALL income must be disclosed and proved with documentation.*

Income examples include:

- *Annual social security statement*
- *Pay stubs for 3 months of income, OR most recent pay stub AND hire date.*
- *Unemployment award letter*
- *Self-employment – most recent tax return and/or 3 month's income and expenses reports*
- *Bank Statements - 3 most recent months of all checking and savings accounts.*
- *Attestation of* ***how expenses are being met*** *if no documentation can be provided.*

Submission of application and documents

- You may hand deliver your completed, signed application and ALL required documents to Sapphire Community Health OR
- Mail to: Sapphire Community Health
  316 N 3rd Street
  Hamilton, MT 59840

IMPORTANT NOTE

YOU MAY QUALIFY FOR MEDICAL BENEFITS THROUGH MEDICAID OR OTHER INSURANCE OPTIONS. PLEASE CONTACT US AT 406-541-7986 TO SEE IF YOU MIGHT QUALIFY FOR INSURANCE BENEFITS.

Sliding Fee Program Application

IF YOU HAVE ANY QUESTIONS CONCERING THIS APPLICATION OR NEED ASSISTANCE, PLEASE DIRECT YOUR QUESTIONS TO OUR PATIENT FINANICAL COORDINATOR AT 406-541-7986.

PATIENT AND APPLICANT INFORMATION

Applicant Name: _____ Birth Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Number: _____ Email: _____

EMPLOYMENT STATUS OF PERSON RESPONSIBLE FOR PAYING BILL

☐ Employed (date of hire: _____) ☐ Unemployed (how long: _____)

☐ Self-Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related to you by birth, marriage, or adoption.

NAME	DOB	RELATIONSHIP TO PATIENT	RECEIVING INCOME?	SOURCE OF INCOME
		Self	Y / N	
			Y / N	
			Y / N	
			Y / N	
			Y / N	
			Y / N	
			Y / N	

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INCOME INFORMATION

You must provide proof of income with your application. Income verification is required to determine eligibility. All family members 18 years or older must disclose their income. Please provide proof of ALL sources of income.

Please provide ALL that are applicable:

- ☐ Current pay stubs (3 months)
- ☐ Social Security / Pension / Retirement Statement
- ☐ Most Current Tax Return
- ☐ Unemployment Compensation Letter
- ☐ Family / Medical Leave Documents
- ☐ Investment Statements
- ☐ Certified Court Orders / Child Support / Spousal Supports
- ☐ Checking and Savings Bank Statements for Last 3 Months
- ☐ Proof of Eligibility for Medicaid / TANF
- ☐ Other: _____

If you have no proof of income or no income, please use the provided confirmation letter for explanation

PATIENT AGREEMENT

I, THE APPLICANT FOR THE SLIDING FEE PROGRAM AFFIRM, THE ABOVE IS TRUE, COMPLETE, AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AGREE TO PROVIDE ANY ADDITIONAL INFORMATION AS REQUESTED IN ORDER TO DETERMINE ELIGIBILITY.

Applicant Signature: _____ Date: _____

- **Intentionally not providing complete documentation will be considered the same as fraudulently attesting to your income.**
- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we will check all the information and may ask for additional information or proof of income.
- Applicants are responsible for notifying Sapphire Community Health of any changes in income.

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