KALISPELL MIDWIVES
& WOMEN'S HEALTH

Sliding Fee Discount Application

It is the policy of Kalispell Midwives & Women's Health to provide essential services regardless of the patient's ability to pay. All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs. Discounts are offered based on family size and annual income for those that are not eligible for alternative payment sources. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this practice, but not those services or equipment that are purchased from outside, including medications. This form must be completed every 12 months or if your financial situation changes.

Name: ____

Place of Employment: ____

Address (City, State, Zip): ____

Phone Number: ____

Date of Birth: ____

Does patient have any form of health or medical insurance, including Healthy Montana Kids, Medicaid, or Medicare? ____ Yes ____ No

If yes, list the company _______________________________ and policy number _______________. *Attach copy of current insurance card.*

Please list spouse and dependents under age 18.

Name	Relationship	Date of Birth

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self -employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name: ____

Signature: ____

Date: ____

Office Use Only

Patient Name: ____

Approved Discount: ____

Approved By: ____

Date Approved: ____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year's tax return, three most recent pay stubs or other		
Insurance: Insurance cards		