GREATER VALLEY
HEALTH CENTER

Income Verification and Sliding Fee Scale Application

Patient Name_____ Date of Birth _____
(Please Print)

Does the patient have any form of health, medical or dental insurance, including Healthy Montana Kids, Medicaid or Medicare? ☐YES ☐ NO

If yes, list the company _____ and policy # _____
Attach copy of current insurance card.

If no, we have Patient Care Coordinator Services to assist with enrollment.

LIST ALL SOURCES OF *CURRENT* GROSS INCOME
FOR EVERY FAMILY MEMBER IN YOUR HOUSEHOLD
(ALL SPACES MUST BE COMPLETED)

Gross (Before taxes) Family Income	Yes	No	Amount Received Weekly	Amount Received Every Other Week	Amount Received Monthly	Which Household Member
Wages						
Wages						
Child Support						
Public Assistance						
Social Security						
Disability						
Workers Compensation						
Retirement/Pension						
Maintenance/Alimony						
Self-Employment						
Unemployment						
Other (Please indicate)						
(To Be Completed by GVHC Staff) **TOTAL:**						

PLEASE CONTINUE ON REVERSE SIDE

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List ALL individuals currently living in the household.

Last Name First Middle	Relationship	Birth Date	Sex	Insurance
	PATIENT		M F	Y N
			M F	Y N
			M F	Y N
			M F	Y N
			M F	Y N
			M F	Y N
			M F	Y N
			M F	Y N
			M F	Y N

TOTAL NUMBER OF HOUSEHOLD MEMBERS _____

Documentation of Income

☐ Tax Return ☐ Copy of Pay Check Stub ☐ Other _____

Please list attachment

Request for Self-Declaration of Income

☐ I am unable to provide income verification because _____

_____

_____

The information given on this form is true to the best of my knowledge.

If I give false information, I may be prosecuted under state and federal laws. I agree to report any changes within 30 days of the change or at my next appointment.

Payment Agreement for Greater Valley Health Center (GVHC)

I accept responsibility to pay for this care, including any balances after insurance payment, according to the fees established. Furthermore, I authorize assignment of benefits for all services to be paid to GVHC. I authorize GVHC to bill my insurance company and provide any information and records necessary for consideration of my claim.

Patient/Guarantor Signature_____ **Date**_____

TO BE COMPLETED BY STAFF:

Slide Co-Payment Amount: __$_____ Staff Initials_____