

Glacier Community Health Center

Application for Sliding Fee Program

Please complete the following:

- **List your household members AND** full dates of birth.
- **Provide current gross income** for the entire household.
- **Supply proof of income** for everyone in the household from one or more of the following:
 - Current year 1040 tax form (include sched F for farming if applicable)
 - **Paycheck stubs** for one full, recent month (preferably with year to date income provided)
 - Office of Public Assistance benefit printout for **TANF income**, any **Alimony award** (*not child support, not SNAP*)
 - Benefits for **Enrolled Tribal Members**
 - **Social Security** – Current year determination statement from SSA (*no bank statements*)
 - **Ranch hands** – if housing is provided, please note the value of rent and utilities that employer pays for
 - **Tip Earners:** Enter the weekly amount you earn in **tips** **HERE: \$** _____

Mailing Address: _____

Phone #: _____

#	First & Last Names	Relation-ship	Birth Date	Gross (before taxes) Household Income	Average # Hours Worked Each Week	Type of Income <small>Choose from the following:</small>	Is this year-round employment?	I get paid on this schedule
1	Please print neatly	SELF		\$		<ul style="list-style-type: none"> ▪ Earned Wages ▪ Self-Employment ▪ Un-employment ▪ TANF ▪ Disability ▪ Social Security ▪ Alimony ▪ Other 	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, how long? _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other wk <input type="checkbox"/> 1 st & 15 th <input type="checkbox"/> Monthly <input type="checkbox"/> Other
2				\$			<input type="checkbox"/> Yes <input type="checkbox"/> No If no, how long? _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other wk <input type="checkbox"/> 1 st & 16 th <input type="checkbox"/> Monthly <input type="checkbox"/> Other
3				\$			<input type="checkbox"/> Yes <input type="checkbox"/> No If no, how long? _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other wk <input type="checkbox"/> 1 st & 16 th <input type="checkbox"/> Monthly <input type="checkbox"/> Other
4								
5								
6								
7								
8								

Total Number of Household Members: _____

Are you eligible to receive services at IHS? Yes _____ No _____

This information is true and accurate to the best of my knowledge, under penalty of perjury.

Signed _____ Date _____

If you are attesting to having NO INCOME, also complete page 2. Otherwise disregard.

Weekly \$ _____ x 52 = _____	OFFICE USE ONLY	Staff Initials: _____ Date: _____
Bi-weekly \$ _____ x 26 = _____		___ renewal
Twice/mo \$ _____ x 24 = _____		___ change to current
Total \$ _____ = _____		___ new applicant
	A B C D E	Date to be renewed: _____

ATTESTATION OF “NO INCOME” PAGE

Glacier Community Health Center Application for Sliding Fee Program

**IGNORE THIS PAGE IF YOU HAVE
INCOME TO REPORT.**

**This page is only for those attesting to NO
income for the entire household at this
time.**

Please Print Your Name: _____

Have you been on GCHC’s sliding fee before? YES NO

If NO, sign page 1 and initial here _____. Skip the rest of the page.

If YES, did you sign that you had zero income? YES NO

IF NO, sign page 1 and initial here _____. Skip the rest of the page.

If YES, please tell us a bit about your living situation. Circle all that apply to the household:

- SNAP
- LIEAP (energy assistance)
- Income based housing
- Food Bank
- WIC
- Other: _____

Please take a moment to describe how you are getting by:

Thank you. You will be notified by mail when your application has been fully processed or if more information is needed to complete your sliding fee application.