PUREVIEW Health Center

1930 9TH AVE
HELENA, MT 59601
PVHC FAX: 406-457-8992

SLIDING FEE APPLICATION

To participate in the PVHC/Parker sliding fee scale program, you must fill out this application and provide proof of your household income. Your income must be verified with **one** of the following: 2 current paycheck stubs from each employer or a copy of your Federal Tax Return, or W-2 or a letter from your employer. We also require proof of SS, SSDI, Grants, Worker's Comp, Unemployment, Retirement, Child Support and Public Cash Assistance.

NAME: _____ DATE: _____

MAILING ADDRESS: _____ PHONE NUMBER: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS	RELATIONSHIP	DATE OF BIRTH	CHC ACCT #
	SELF		

Who in your household is employed?
Name: _____ How often do you get paid? _____
Name: _____ How often do you get paid? _____
Income coming into the home:

Child Support:	Unemployment:	Alimony:
Retirement:	Worker's Comp:	Social Security:
Welfare:	Disability:	Educational Grants:
Food Stamps:	Other:	

- My signature below authorizes the PVHC/Parker to release my financial information to St. Peter's Hospital or any other medical institution to assist in determining a discount at those institutions.
- I understand that I may be prosecuted under applicable state or federal laws for giving fraudulent information to obtain discounted services at the PureView Health Center/Parker Medical Center.
- By signing this form, I affirm that all information given is an accurate statement of income at the time of this application.

Signature of Applicant_____Date:_____

For Office Use Only: Number of Dependents:_____ Yearly Income:_____
Income Code:_____Expiration Date:_____