

Glacier Community Health Center and Glacier Dental Clinic are federally funded government programs. This allows us to provide healthcare services to individuals regardless of their ability to pay. Because we receive federal grants, we are required to gather information on household size and income for the patients we serve.

**Please note: Your personal information is confidential. It is not disclosed to anyone and is only used to develop statistics regarding our use of federal funds.**

**In what level does your family income fall (1 – 4)?**

Find your family size on the left column, then follow that row to your amount of family income; circle that column.

**PLEASE CIRCLE 1, 2, 3, OR 4 FOR INCOME OF HOUSEHOLD.**

**Federal Schedule of Income 2021**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Family** |  | **1** | | **2** | | **3** | | **4** | |
| **Size** |  | **From** | **To** | **From** | **To** | **From** | **To** | **From** | **To** |
| 1 | Yr | 0 | $12,880 | $12,881 | $19,320 | $19,321 | $25,760 | $25,761 | and over |
| 2 | Yr | 0 | 17,420 | 17,421 | 26,130 | 26,131 | 34,840 | 34,841 | and over |
| 3 | Yr | 0 | 21,960 | 21,961 | 32,940 | 32,941 | 43,920 | 43,921 | and over |
| 4 | Yr | 0 | 26,500 | 26,501 | 39,750 | 39,751 | 53,000 | 53,001 | and over |
| 5 | Yr | 0 | 31,040 | 31,041 | 46,560 | 46,561 | 62,080 | 62,081 | and over |
| 6 | Yr | 0 | 35,580 | 35,581 | 53,370 | 53,371 | 71,160 | 71,161 | and over |
| 7 | Yr | 0 | 40,120 | 40,121 | 60,180 | 60,181 | 80,240 | 80,241 | and over |
| 8 | Yr | 0 | 44,660 | 44,661 | 66,990 | 66,991 | 89,320 | 89,321 | and over |
| For family units of more than 8 members, add $4,540 for each additional member. | | | | | | | | | |

If you circled columns 1, 2, or 3, you may be eligible for our sliding fee discount program. You can get between 20% and 100% off your health care bill, with only a $20 co-pay per visit. The next step is to complete the Financial Worksheet and provide the necessary proof of income.

Please Select Option and Sign Below:

\_\_\_\_\_ Yes, I’m interested in applying for sliding fee.

\_\_\_\_\_ No, I’m not interested in applying for sliding fee.

I realize that if I do not qualify for the sliding fee discount or choose not to apply for it, I will be responsible for making full payment. I know that I may apply for the sliding fee discount at any

time I receive service.

Patient Signature: Date: