Daniels Memorial
HEALTHCARE CENTER

DANIELS MEMORIAL HEALTHCARE CENTER SLIDING FEE SCALE APPLICATION

Sliding Fee Discount Information

It is the policy of DANIELS MEMORIAL HEALTHCARE CENTER to provide essential services regardless of the patient's ability to pay. DANIELS MEMORIAL HEALTHCARE CENTER offers discounts based on family size and annual income.

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 facility, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

| NAME | | | | |
|---|---|---|---|---|
| STREET | CITY | STATE | ZIP | PHONE |
| | | | | |

**Please list all household members, including those under age 18.**

| | Name | Date of Birth |
|---|---|---|
| **SELF** | | |
| **OTHER** | | |
| **OTHER** | | |
| **OTHER** | | |


Phone: 406.487.2296 | Fax: 406.487.2471 | PO Box 400 • 105 5th Avenue East, Scobey, MT 59263

Daniels Memorial
HEALTHCARE CENTER

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

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

PLEASE PROVIDE THE FOLLOWING UPON COMPLETION

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

Self-declaration of income may also be used.

Name (Print)

Signature

Date

**Office Use Only**

**Patient Name:**
**Approved Discount:**
**Approved by:**
**Date Approved:**