RiverStone Health Clinic
Sliding Fee Scale Eligibility Determination

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 number _____
Attach copy of current insurance card.

Number of Dependents in Household (*including self*) _____

Please list dependents living in household:

	NAME	DATE OF BIRTH
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Gross (before taxes) Monthly Income Amount $_____

Type of Documentation of Income: (Attach Copy)

- ❑ Copy of Pay Check Stub Date _____
- ❑ Copy of Income Tax Form Date _____
- ❑ Child Support Date _____
- ❑ Other _____ Date _____

The information I have listed above is true and complete. I understand that if it is later found that I did not truly qualify for the sliding fee scale that I may be responsible for repayment of any discounts that I received but was not entitled to. I understand that a person who obtains or attempts to obtain, by fraudulent means, services to which they are not entitled, may be prosecuted under applicable state and federal laws. **I agree to report any changes in the above information.**

Patient Signature: _____ Date: _____

Please fax, mail or bring to RiverStone Health Clinic, 123 South 27th Street, Billings, MT 59101.
Fax – (406) 247-3389