

# Blacktail Health

## Sliding Fee Discount Program Application

Patient or Legal Guardian \_\_\_\_\_ DOB \_\_\_\_\_  
 SSN \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Blacktail Health offers a sliding fee discount program to all who qualify. To be eligible, a patient must have household income below 200% of the Federal Poverty Level (FPL), which is based on pre-tax income and size of household. We request income information from all of our patients, regardless of eligibility/participation. It is used to calculate sliding fee discounts and to report summary information for our grant, which allows us to offer these discounts.

**Number of people in household** \_\_\_\_\_ **Estimated annual household income** \_\_\_\_\_

- I wish to participate in the sliding fee discount program, but I don't have proof of income with me today. I understand that my account will remain at full pay until I have provided acceptable proof of my household's income. Discounts will be applied up to 60 days retroactively once proof is provided.
- I wish to participate in the sliding fee discount program and/or medication assistance at Blacktail Health facilities, and I have proof of income with me today.

Proof of at least one month's worth of the most current household income is required when applying for a sliding fee discount. Any changes in income or household size need to be reported to our clinic. If no proof is received, your account will remain at full pay until proof is provided. Discounts can be applied up to 60 days retroactively from when proof is received.

The sliding fee discount applies **ONLY** to services provided.  
 Medications, labs, & equipment **DO NOT** qualify, but are offered at reduced rates.

I fully understand that I must submit complete information for all household income. I understand that any person who obtains or attempts to obtain services or discounts to which they are not entitled may be prosecuted under applicable State and Federal law.

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- I **do not** wish to participate in the sliding fee program/refuse application.

We understand that you are not interested in applying for the sliding fee discount program. If you are comfortable sharing your income information, we would appreciate it. This information helps us meet federal reporting requirements and demonstrates that we are serving patients from all income levels. Your information is kept confidential and will not affect the cost of your visit.

**Number of people in household** \_\_\_\_\_

Annual household income before taxes (Please select category)

- < \$20,000
- \$20,000 - \$40,000
- \$40,000 - \$60,000
- \$60,000 - \$80,000
- \$80,000 - \$100,000
- > \$100,000

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**STAFF USE ONLY**

January 2026

Income:	Fam size:	Staff Initials:
Status:	Reason:	Proof of income:
Guarantor Legal Name:		DOB:

Date Received \_\_\_\_\_

**NOTES:**