I voluntarily request services from Bridgercare. I authorize Bridgercare to release any information necessary to process my insurance benefits to be paid directly to Bridgercare. I accept full financial responsibility for any uncovered costs based on my sliding fee assignment. I understand that I may set up a payment plan. Amounts with no payments for more than 90 days may be released to an outside agency for collection with reporting of same to credit bureaus. Essential services will not be denied for inability to pay.

Patient Signature: _____ Date: _____

Do you have insurance, Medicaid or Montana Cancer Control Program coverage? Yes No

Insurance coverage does NOT affect your eligibility for our discounts.

_____ I do not want to be considered for sliding fees. I understand that if I am insured, I may be left with a balance or copay. I also understand that I cannot retroactively be considered for sliding fees for this date of service.

Initial here: _____

_____ I wish to be considered for sliding fees. *Please complete the box below.*

Please fill out this box in order to be considered for reduced fees.
We may request income verification.
Record your income BEFORE taxes. This is your gross income.
Inclusion of a spouse or co-habitating sexual partner's income is required by our Federal grant regardless of how you share expenses. Thank you!

Staff use only.

Number of household members (including yourself): _____

Your Current Employment:	_____ hrs/wk at $_____ an hour **or** salary $_____ per year before taxes.	_____
If you have a 2nd job:	_____ hrs/wk at $_____ an hour **or** salary $_____ per year before taxes.	_____
Partner's Employment:	_____ hrs/wk at $_____ an hour **or** salary $_____ per year before taxes.	_____
If he/she has a 2nd job:	_____ hrs/wk at $_____ an hour **or** salary $_____ per year before taxes.	_____

Other Income:	tips/commission	$_____ per week	_____
	parental support	$_____ per month	_____
	grants/stipends/scholarships	$_____ per month	_____
	trust accounts	$_____ per month	_____
	unemployment/disability	$_____ per month	_____
	child support/alimony	$_____ per month	_____
	rental income that you receive	$_____ per month	_____
	other income	$_____ per month	_____

FEMALE PATIENTS WITHOUT INSURANCE ONLY:

Are you a female age 19-44?	Y	N
Are you pregnant or seeking pregnancy?	Y	N
Are you able to get pregnant?	Y	N
Are you a US Citizen & a Montana Resident?	Y	N

PLANFIRST:
Yes No

Monthly Income:
_____

Inc verif needed?
Yes No Under 22

Date:
Staff Initials:

Fee Scale:
1 2 3 4 5

updated 2-25-14