PUREVIEW Health Center
1930 9TH Ave, Helena, MT 59601
Phone: 406-457-0000 Fax 406-500-2130

SLIDING FEE DISCOUNT PROGRAM APPLICATION

- No one will be denied care due to inability to pay.
- Sliding fee discounts are available to patients only based on **INCOME** and **FAMILY SIZE**, and no other factors.
- **We will backdate eligibility for discounts if you bring required documentation within 45 days of the visit.**
- You need to reapply yearly for Sliding Fee Discount Program to be reassessed for eligibility.

NAME:_____ DATE: _____

MAILING ADDRESS:_____ PHONE NUMBER: _____

CITY: _____ STATE: _____ ZIP: _____

Please list all individuals, including yourself, that meet one of the following criteria:

- ***All individuals that can be claimed by guarantor on Federal or State income tax returns***
- ***All individuals, who may or may not live together, who share gross income***

FAMILY MEMBERS	RELATIONSHIP	DATE OF BIRTH	PureView ACCT # (Office Use Only)
	SELF		

PureView uses IRS Federal Tax Return Total Income as a guideline for income determination plus additional items listed below.

For EVERYONE listed above, please list a yearly amount below for any income item that applies:

Income Category	Yearly Amount ($$)
Wages, salaries, tips etc.	
Interest, dividends	
Taxable refunds, credits, or offset of state and income taxes	
Alimony received	
Self-employment, business income	

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Income Category	Yearly Amount ($$)
Capital Gains, other gains	
Retirement	
Pensions and annuities	
Rental income, trusts etc.	
Farm income	
Unemployment	
Social Security Benefits	
Any Other income	
Supplemental Security Income (SSI)	
Any cash public assistance or welfare payments from the state or local welfare office	
Veteran's (VA) payments	
Workers' compensation	
Child support received	

Your income will be reduced by the following items. Please list yearly amount for any item that applies to you:

Income Category	Yearly Amount ($$)
Alimony paid	
Child support paid	

The following documentations are acceptable for verification of income or change of income. Please provide any documentation from the list below to support your income.

Acceptable Income Documentation
Most recent Federal Tax Returns
Two most current paycheck stubs or most current W2
Letter from employer
If self-employed, detail of the most recent three months of income and expenses for the business or most current 1099
Unemployment checks or letter from unemployment office
Public assistance verification letter
Social Security Statement (Award Letter)
Retirement Account Statements
Copy of checks or bank statements that prove the income (VA, Child Support (2 most recent payments or receipts), Alimony etc.

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- *My signature below authorizes the PureView Health Center to release my financial information to St. Peter's Health or any other medical institution to assist in determining a discount at those institutions.*
- *I understand that I may be prosecuted under applicable state or federal laws for giving fraudulent information to obtain discounted services at the PureView Health Center/Parker Medical Center.*
- *By signing this form, I affirm that all information given is an accurate statement of income at the time of this application.*

Signature of Applicant_____Date:_____

For Office Use Only:

Date of application received: _____

Sliding Fee Discount Program Eligibility Effective Date (the earliest appointment date within 45 days from application received date): _____

Number of Dependents:_____ Yearly Income: _____
Income Code:_____ Expiration Date: _____

NOTES/COMMENTS:

PUREVIEW HEALTH CENTER

NO ONE WILL BE DENIED CARE DUE TO THE INABILITY TO PAY. PLEASE CONTACT THE BILLING OFFICE TO SEE IF YOU QUALIFY FOR THE SLIDING FEE DISCOUNT PROGRAM.

Effective 02/01/2025 (updated yearly based on federal poverty guidelines)

Sliding fee discounts are available to patients based only on INCOME and FAMILY SIZE, and no other factors.

Annual Income Thresholds by Sliding Fee Discount Pay Class & Percent Poverty

Poverty Level*	At or Below 100%	>100% - 125%	>125% - 150%	>150% - 175%	>175% - 200%	Above 200%
Family Size	INCOME LEVEL					
1	$ - $ 15,650	$ 15,651 - $ 19,563	$ 19,564 - $ 23,475	$ 23,476 - $ 27,388	$ 27,389 - $ 31,300	$ 31,301 +
2	$ - $ 21,150	$ 21,151 - $ 26,438	$ 26,439 - $ 31,725	$ 31,726 - $ 37,013	$ 37,014 - $ 42,300	$ 42,301 +
3	$ - $ 26,650	$ 26,651 - $ 33,313	$ 33,314 - $ 39,975	$ 39,976 - $ 46,638	$ 46,639 - $ 53,300	$ 53,301 +
4	$ - $ 32,150	$ 32,151 - $ 40,188	$ 40,189 - $ 48,225	$ 48,226 - $ 56,263	$ 56,264 - $ 64,300	$ 64,301 +
5	$ - $ 37,650	$ 37,651 - $ 47,063	$ 47,064 - $ 56,475	$ 56,476 - $ 65,888	$ 65,889 - $ 75,300	$ 75,301 +
6	$ - $ 43,150	$ 43,151 - $ 53,938	$ 53,939 - $ 64,725	$ 64,726 - $ 75,513	$ 75,514 - $ 86,300	$ 86,301 +
7	$ - $ 48,650	$ 48,651 - $ 60,813	$ 60,814 - $ 72,975	$ 72,976 - $ 85,138	$ 85,139 - $ 97,300	$ 97,301 +
8	$ - $ 54,150	$ 54,151 - $ 67,688	$ 67,689 - $ 81,225	$ 81,226 - $ 94,763	$ 94,764 - $ 108,300	$ 108,301 +
For each additional person, add	$ 5,500	$ 6,875	$ 8,250	$ 9,625	$ 11,000	$ 11,001

*based on 2025 Federal Poverty Guidelines (https://aspe.hhs.gov/poverty)

The CHC is funded through the U.S. Department of Health and Human Services Bureau of Primary Care. This health center is a Health Center Program grantee under 42 U.S.C. 254b, and is deemed a Public Health Service employee under 42 U.S.C. 233(g)-(n).

	CHARGE PER VISIT					
PRIMARY CARE SERVICE						
Medical and Psychiatric Provider Office Visit	Nominal Charge $5.00	Flat Fee $20	Flat Fee $35	Flat Fee $50	Flat Fee $65	Full Fee

	CHARGE PER VISIT FOR EACH SERVICE GROUP WHEN PRIMARY CARE ANCILLARY SERVICES PROVIDED WITHIN PRIMARY CARE VISIT, THESE SERVICES ARE CONSIDERED PART OF THAT VISIT					
PRIMARY CARE ANCILLARY SERVICE						
Vaccination per Visit	$ -	Flat Fee $2	Flat Fee $3	Flat Fee $4	Flat Fee $5	Full Fee
Lab	$ -	Flat Fee $2	Flat Fee $4	Flat Fee $6	Flat Fee $8	
Injection Administration per Visit (includes injections)	$ -	Flat Fee $5	Flat Fee $10	Flat Fee $15	Flat Fee $20	
Medical Procedures per Visit (including IUDs and other supplies)	$ -	Flat Fee $8	Flat Fee $10	Flat Fee $12	Flat Fee $14	

	CHARGE PER VISIT FOR EACH SERVICE GROUP					
Chronic Care Management						
OTHER SERVICES						
Mental Health Counseling Services per Visit	$ -	Flat Fee $2	Flat Fee $4	Flat Fee $6	Flat Fee $8	Full Fee
Clinical Pharmacist Service per Visit						
Peer Support Services per Visit						
Diabetes and Nutrition Services per Visit						
Dental Services						

	CHARGE PER VISIT					
DENTAL SERVICES						
	Nominal Charge $7	35% pay	45% pay	55% pay	65% pay	Full Fee

Chair, PVHC Governing Board — Date 6/26/25

CEO — Date 8.26.25

CFO — Date 8.26.25

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Effective 02/01/2025 (updated yearly based on federal poverty guidelines)

OBSTETRICAL, LABS & RADIOLOGY SERVICES (PROVIDED THROUGH ST. PETER'S HEALTH) SLIDING FEE DISCOUNT SCHEDULE

Sliding fee discounts are available to patients based only on INCOME and FAMILY SIZE, and no other factors.

Annual Income Thresholds by Sliding Fee Discount Pay Class & Percent Poverty

Poverty Level*	A At or Below 100%	B >100% - 125%	C >125% - 150%	D >150% - 175%	E >175% - 200%	F Above 200%
Family Size	INCOME LEVEL					
1	$ - - $ 15,650	$ 15,651 - $ 19,563	$ 19,564 - $ 23,475	$ 23,476 - $ 27,388	$ 27,389 - $ 31,300	$ 31,301 +
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For each additional person, add	$ 5,500	$ 6,875	$ 8,250	$ 9,625	$ 11,000	$ 11,001

*Based on 2025 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)

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Chair, PVHC Governing Board — Date 6/25/25

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