Family Medicine Health Center Sliding Fee Application

Patient Name:	
Address:	
City, State, Zip Code:	
Telephone (circle one): Home/ Cell/ Work/ Other:	
Date of Birth:	
Social Security Number:	

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence. Your annual household income will be used to calculate the level of your payment.

Do you have Medicaid?	☐ Yes ☐ No
Do you have Medicare?	☐ Yes ☐ No
Do you have Veterans Assistance (VA)?	☐ Yes ☐ No
Do you have Health Insurance?	☐ Yes ☐ No
Would you like additional information on the health insurance exchange?	☐ Yes ☐ No

Family Size? **Are you applying for pregnancy related assistance (OBO) program?** ☐ Yes ☐ No

Are you applying for integrative health related assistance for services such as acupuncture, cupping, etc? ☐ Yes ☐ No

What is your marital status? ☐ Single ☐ Married ☐ Widow(er) ☐ Divorced ☐ Separated

Are you a U.S. Citizen? ☐ Yes ☐ No **Place of Birth (State or Country):**

If No, are you a Permanent Resident? ☐ Yes ☐ No **Alien ID#:** **Issue Date:**

Gross annual income **before taxes** must include all sources of income (wages, Social Security,unemployment, income from assets, pension, child support.)
If you have NO Income, please initial here. ________ (*Additional forms will need to be filled out.*)

Employer Name	Start Date	Hours p/ week	$ paid	☐ Hourly ☐ Salary	☐ Weekly	☐ Every 2 Weeks	☐ Bi-Monthly	☐ Monthly
Employer Name	Start Date	Hours p/ week	$ paid	☐ Hourly ☐ Salary	☐ Weekly	☐ Every 2 Weeks	☐ Bi-Monthly	☐ Monthly
Employer Name	Start Date	Hours p/ week	$ paid	☐ Hourly ☐ Salary	☐ Weekly	☐ Every 2 Weeks	☐ Bi-Monthly	☐ Monthly
Employer Name	Start Date	Hours p/ week	$ paid	☐ Hourly ☐ Salary	☐ Weekly	☐ Every 2 Weeks	☐ Bi-Monthly	☐ Monthly

Do you receive any income from any of the following sources, and if so, how much per month?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security/ Retirement Pension					
Public Assistance					
Unemployment/ Workers Compensation					
Food Stamps					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (Specify)					

Please list your spouse and/or any tax dependents that are living in the household. (Use an extra piece of paper if needed)

Name:	Date of Birth:	Relationship to Patient:
1.		
2.		
3.		
4.		
5.		
6		

1. I certify the information provided here is true, complete and accurate.
2. I give Family Medicine Health Center permission to share my information with other organizations, grantors or providers (and their auditors) that provide discounted services to me at the request of Family Medicine Health Center. Examples of such organizations are Patient Medication Assisstance Program, referral networks, laboratories, medical imaging services, or medical specialists, etc.
3. I understand intentionally providing false information may exclude me from discounts at Family Medicine Health Center. I may be billed for any discounts I received with false information. I understand that I must provide verification of income, financial assistance, dependents, bank statements, pay vouchers and tax statements if applicable.
4. I understand that if I am approved the Sliding Fee Program is in effect for 12 months from the date of approval. I will promptly notify Family Medicine Health Center if my financial status changes (i.e. change in family size, change in employment, new employment, qualify for other assistance, etc.). If I need assistance after 12 months, I understand that I must re-apply for the Sliding Fee Program by submitting a new application with new supporting documents.

Patient/ Guardian Signature: **Date:**

INSTRUCTIONS ON OTHER SIDE

Application Instructions

1. Applications may be completed and submitted at **https://secure.fmridaho.org/portal/default.aspx**
2. Only use **dark blue** or **black** ink when filling out the application
3. Fill out the application completely and return all documentation within **10 days** to Family Medicine Health Center.
   This application can be dropped off at any of our clinics as well as mailed or faxed to: **Fax #: 208-322-7018**
   Family Medicine Health Center
   Attn: Sliding Fee
   777 N Raymond St
   Boise, ID 83704
4. If a field and/or section does note apply to you, it must be filled out with "N/A." Incomplete applications will not be processed until all information needed to process the application has been provided.
5. Discounts will be based on family/household income and family size. **Family is defined as:**
   a. **Definition of family limited to spouse and/or dependents ("qualifying child" or "qualifying relative") per IRS definitions in Title 26, Section 151-152 of the tax code.**
6. If you have questions please contact our Financial Assistance Coordinator at **208-514-2500 ext. 3465**

Copies of documents that must be attached to the application include:

1. A copy of a valid identification card or driver's license.
2. If applying for pregnancy related assistance (OBO), applicants eligible to apply for Medicaid must provide Medicaid denial letter
3. A copy of any and all income received for all family members (both adult and children) living at the same residence will need to be disclosed and verified on the application. *See table below*
4. A personal statement as to why you are not working for any adults that are not working.

✓	Income Type	Verification Needed
	No Income	Sign the "Self-Declaration of Household Income," and have person helping you fill out the "Supplemental Contribution Statement."
	Earnings from employment	Copy of 30 days most recent wage/pay stubs or letter from employer stating hourly/salary rate and hours per week expected to work.
	Earning from self-employed business	Profit/ loss statement for the last 3 months and most recent year's tax return
	Unemployment compensation	Unemployment benefits in the form of a eligibility determination or benefit payment summary (must be able to see benefit amount remaining or weeks remaining of benefit)
	Workers' compensation	Workers' compensation benefits in the form of a eligibility determination or benefit payment summary
	Social Security	Bank statement or social security determination letter from the last 30 days
	Supplemental Security Income	Bank statement or social security determination letter from the last 30 days
	Public assistance	Bank statement or letter of determination from the last 30 days
	Veterans' payments	Bank statement or Veterans' payments determination letter from the last 30 days
	Survivor benefits	Bank statement or survivor benefits determination letter from the last 30 days
	Pension or Retirement income	Bank statement or Pension or Retirement statement from the last 30 days
	Savings or Checking account funds	Bank statement for the last 90 days
	Interest and/or Dividends	Bank statement or Interest statement from the last 90 days
	Rents, Royalties, Trusts	Bank statement from the last 30 days
	Income from estates	Bank statement from the last 30 days
	Educational assistance (Financial Aid/Grants/Scholarships/Loans)	Bank statement showing direct deposit refund received from school or student loan/student grant information sheet. This sheet will show the total loan(s) and/or grant(s) received and the tuition expenses for the current semester/year
	Alimony	Bank statement from the last 30 days
	Child support	Child support history from Dept. of Health and Welfare for the last 5 payments even if no payment s have been received.
	Assistance from outside the household or miscellaneous sources.	Have whoever is providing you assistance fill out the "Supplemental Contribution Statement."
	Noncash benefits (food stamps and housing subsidies) do not count	No verification needed

APPLICATION ON OTHER SIDE

FAMILY MEDICINE HEALTH CENTER

SELF-DECLARATION OF HOUSEHOLD INCOME

I, _____understand that the amount I am charged for FMHC services depends on my household income. I understand that household income includes my income and the income of all family members living with me.
I understand that "income" includes, but is not limited to:

- pay, wages, or salaries
- tips
- unemployment benefits
- social security benefits
- welfare benefits
- disability, worker's compensation or other payments for an injury or illness
- retirement or pension benefits
- alimony or child support payments
- insurance or annuity payments to me
- interest or dividends from savings accounts or investments
- rental income or other income from a business
- income from royalties, patents, gambling, sweepstakes or lottery winnings
- inheritance, gifts and grants

I understand that if the members of my household have any of these types of income, I must tell the eligibility worker about them and include the income in the estimate. I also understand that if I provide false information I will be disqualified from the FMHC Sliding Fee Discount Program and all charges will be due in full immediately. I declare that my estimated yearly household income is $_____.
BY SIGNING THIS FORM, I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF IDAHO THAT THE INFORMATION I AM PROVIDING IS TRUE AND CORRECT.

Name of Applicant/Guardian (printed): _____

Date: _____

Signature of Applicant/Guardian:

_____

FAMILY MEDICINE HEALTH CENTER

Supplemental Contribution Statement
For FMHC Financial Assistance Programs

This form is to be COMPLETED and SIGNED by the person helping the applicant. Additional Supplemental Contribution Statements are required for each individual who provides assistance to the applicant.

Applicant's Full Name: _____ Phone #: (___) _____-_____

☐ I provide the Applicant a place to live, at no cost to the applicant, which is valued at $_____ per month.
*****Please note, value of housing should reflect the fair market value for the space provided to the applicant.**

☐ I provide the Applicant with financial assistance (cash, check etc.) to be used applied to housing expenses in the monthly amount of $ _____.
*****Please note, value of housing should reflect the fair market value for the space provided to the applicant.**

☐ I provide groceries or financial assistance (cash, check etc.) to be applied to grocery expenses in the monthly amount of $_____.

☐ I provide car payments or financial assistance (cash, check etc.) to be applied to car payments in the monthly amount of $ _____.

☐ I provide credit card payments or financial assistance (cash, check etc.) to be applied to credit card payments in the monthly amount of $ _____.

☐ I provide utility payments or financial assistance (cash, check etc.) to be applied to monthly utility payments as follows;

Power: $_____ Gas: $_____ Water: $_____ Trash: $_____ Sewer: $_____

☐ I provide phone payments or financial assistance (cash, check etc.) to be applied to phone payments in the monthly amount of $ _____.

☐ I provide health care payments or financial assistance (cash, check etc.) to be applied to health care payments as follows;

Hospital: $_____ Dental: $_____ Prescription: $_____ Primary Care: $_____

☐ I provide miscellaneous financial assistance (cash, check etc.) to the applicant in the monthly amount of $ _____.

☐ I provide personal hygiene items or financial assistance (cash, check etc.) to be applied to personal hygiene items in the monthly amount of $ _____.

☐ I provide _____ or financial assistance (cash, check etc.) to be applied to _____ in the monthly amount of $ _____.

I hereby certify that the information listed above is true and correct. I understand that the Applicant is applying for financial assistance through the FMHC Financial Assistance Program and that falsifying information could lead to financial consequences for the Applicant including termination of previous and future financial assistance.

Printed Name: _____

Signature: _____

Date: _____ Phone #: (____) _____-_____

Address: _____

Relationship to the Applicant: _____