Family Medicine Health Center Sliding Fee Application

Responsible Party Name:	
Address:	
City, State, Zip Code:	
Telephone (circle one): Home/ Cell/ Work/ Other:	
Date of Birth:	**Sex:** ☐ Male ☐ Female
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.

Does anyone have Medicaid?	☐ Yes ☐ No
Does anyone have Medicare?	☐ Yes ☐ No
Does anyone have Veterans Assistance (VA)?	☐ Yes ☐ No
Does anyone have Health Insurance?	☐ Yes ☐ No
Would anyone 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

Please list each family members current employer and fill out ALL fields related to that persons employment. If your family household hase NO Income, please initial here. ________ (*Additional forms will need to be filled out.*)

#	Employer Name / Name of Person Employed	Start Date	Hours p/ week	Hourly or Salary Amount Paid					
1	Employer Name Name of Person Employed	Start Date	Hours p/ week	Hourly or Salary Amount Paid	☐ Hourly ☐ Salary	☐ Weekly	☐ Every 2 Weeks	☐ Bi-Monthly	☐ Monthly
2	Employer Name Name of Person Employed	Start Date	Hours p/ week	Hourly or Salary Amount Paid	☐ Hourly ☐ Salary	☐ Weekly	☐ Every 2 Weeks	☐ Bi-Monthly	☐ Monthly
3	Employer Name Name of Person Employed	Start Date	Hours p/ week	Hourly or Salary Amount Paid	☐ Hourly ☐ Salary	☐ Weekly	☐ Every 2 Weeks	☐ Bi-Monthly	☐ Monthly

Do you or anyone in your family household 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	$	$	$	$	$
Unemployment/ Workers Compensation	$	$	$	$	$
Income from Rental Property	$	$	$	$	$
Child Support, Alimony	$	$	$	$	$
Other (Specify) Ex: Interest Income	$	$	$	$	$

Please list each family member who lives in your household. This includes parents and children, but not extended family members. Use a separate piece of paper if extra space is needed. Only one form is required per family.

Name #1:	DOB: / /	Relationship:
Name #2:	DOB: / /	Relationship:
Name #3:	DOB: / /	Relationship:
Name #4:	DOB: / /	Relationship:
Name #5:	DOB: / /	Relationship:
Name #6:	DOB: / /	Relaionship:

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.

Responsible Party Signature:	
If Not Patient, Relationship to Patient:	**Date:**

INSTRUCTIONS ON OTHER SIDE

Application Instructions

1. Only use **dark blue** or **black** ink when filling out the application.
2. Fill out the application completely and return all documentation within **10 days** to Family Medicine Health Center.
3. This application can be dropped off at any of our clinic locations, e-mailed to: registration@fmridaho.org, faxed to: **Fax #: 208-322-7018,** or mailed to the address below:

   Family Medicine Health Center
   Attn: Sliding Fee
   777 N Raymond St
   Boise, ID 83704
4. **ALL FIELDS MUST BE COMPLETED.** 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 **208-514-2515 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 for all adults.
2. 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 included and verified on the application. *See table below*
3. A personal statement as to why you are not working for any adults in the household.

✓	**Income Type**	**Verification Needed**
	No Income	Sign the "Self-Declaration of Household Income," and a written note about where the patient is receiving help from
	Earnings from employment	Copy of 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 or 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	Social security determination letter or bank statement from the last 30 days
	Supplemental Security Income	Bank statement or social security determination letter 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
	Rental Income from Property, 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.

APPLICATION ON OTHER SIDE