INNOVATIVE
HEALTH CARE CONCEPTS
115 E. 16th Street | Idaho Falls, ID 83404 | t. 208.523.6727 | f. 208.523.6729
Integrated Services Center

Sliding Fee Scale Application

Patient Information	Today's Date: / /			
First Name:	Middle Initial:	Last Name:		
Mailing Address:		City:	State:	Zip:
Phone #:				

NOTE: Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount for services received at Innovative Health Care, Integrated Services department. Your answers will be kept on file and in strict confidence. You must verify your income every year. Either your annual income tax return, a copy of your W-2 form, last 3 paycheck stubs, copies of your social security checks, or other earned income checks you may receive will be sufficient proof of income. Only your income and your family size will be used to calculate your discount.

Household Size	Name	Date of Birth
Self		
Other		
Other		
Other		
Other		
Other		

Income Source	Check One:				
Income Received from:	**Monthly**	**Annual**	**Self**	**Spouse**	**Other**
Gross wages, salaries, tips, etc.					
Business and Self-Employment					
Unemployment compensation or worker's compensation					
Social Security, Supplemental Security Income, Public Assistance (Food Stamps)					
Child Support, Alimony					
Pension or Retirement benefits					
Survivor Benefits, veteran payments, educational assistance					
Interest, dividends, royalties, estate income, trusts					
Other:					

The date the application is submitted will be the date any eligible discounts will apply to your services. In the event an application is submitted without the required documentation, you will be notified and given 14 days from notification to submit the documentation without moving the submission date forward. If you do not submit the required documentation within the required 14-day time period, the application will be denied and you will be required to re-submit the application.

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I further agree to inform Innovative Health Care Concepts, Inc. if there is a significant change in my income within thirty (30) days. Sliding fee payment is due and payable at the time of service unless other arrangements have been made.

Date:_____ Name (Print):_____

Signature: _____

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Please attach at least one item from each applicable section below to complete your application. Incomplete applications will not be considered for discount.

Verification Checklist Attach a copy of each item below with your application. Failure to provide verification will result in a denied application.	**Yes**	**No**
Income: • Prior year tax return, OR • **Three** most recent pay stubs, OR • W-2 or 1099, Form 4506-T	☐	☐
Optional: Insurance (if applicable): • Insurance card(s)	☐	☐
In the event you are unable to provide income verification please provide a signed written statement indicated your monthly income.	☐	☐

You may be eligible for Medicaid benefits. Please let our office staff know if you are interested in learning more.

Schedule of Income Thresholds Based upon 2021 Federal Poverty Guidelines

Annual Income Thresholds by Sliding Fee Discount Pay and Percent Poverty						
Poverty Level	**At or Below 100%**	**125%**	**150%**	**175%**	**200%**	**Above 200%**
	Charge					
Family Size	**0% Pay**	**20% pay**	**40% pay**	**60% pay**	**80% pay**	**100% pay**
1	0-$12,880	12,881-16,100	16,101-19,320	19,321-22,540	22,541-25,760	25,761+
2	0-$17,420	17,421-21,775	21,776-26,130	26,131-30,485	30,486-34,840	34,841+
3	0-$21,960	21,961-27,450	27,451-32,940	32,941-38,430	38,431-43,920	43,921+
4	0-$26,500	26,501-33,125	33,126-39,750	39,751-46,375	46,376-53,000	53,001+
5	0-$31,040	31,041-38,800	38,801-46,560	46,561-54,320	54,321-62,080	62,081+
6	0-$35,580	35,581-44,475	44,476-53,370	53,371-62,265	62,266-71,160	71,161+
7	0-$40,120	40,121-50,150	50,151-60,180	60,181-70,210	70,211-80,240	80,241+
8	0-$44,660	44,661-55,825	55,826-66,990	66,991-78,155	78,156-89,320	89,321+
For each additional person, add	$4,540	$5,675	$6,810	$7,945	$9,080	$9,081+

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To be completed by Innovative Health Care Staff:

Patient Name:_____ DOB: _____

- ❑ Patient is not eligible for Sliding Fee Discount Program based on income verification provided
- ❑ Patient is eligible for sliding fee discount. Patient will receive a _____% reduction in pay

Verification completed by (please print): _____

_____ _____

Signature Date