INNOVATIVE
HEALTH CARE CONCEPTS
790 S. Holmes Ave. | Idaho Falls, ID 83401 | t. 208.529.8526 | f. 208.529.8597
Trusted Guidance, Quality Care

SLIDING FEE SCALE APPLICATION

IHCC Mental Health Services

Patient Information		Today's Date: / /		
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Mobile Phone #: ( ) -		
Date of Birth: / /	Social Security # - -	Do you have insurance? (circle one) Yes No		
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Income			
Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

NOTE: To comply with federal regulations, in order to give you a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.
Your yearly income tax return, a copy of your W-2 form, last 3 paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

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 and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Innovative Health Care's Testing and Counseling Center if there is a significant change in my income within thirty (30) days. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Innovative Health Care. I understand that the information I have provided is subject to verification by the Testing and Counseling Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

I understand that if my required documentation is not submitted, my application will be considered incomplete and discarded.

Sliding fee payment is due and payable at the time of service unless other arrangements have been made.

Date:__________________________ Name (Print):____

Signature:____

Please attach at least one item from each applicable section below to complete your application. Incomplete applications will be returned.

Verification Checklist (attach copies)	**Yes**	**No**
*Identification/Address (Submit one of the following): • Driver's license • Birth certificate • Social Security Card or • Other: ___________________________________	☐	☐
*Income: • Prior year tax return • **Three** most recent pay stubs • W-2 or 1099 • Other: ____________________________________	☐	☐
Insurance (if applicable): • Insurance card(s)	☐	☐
** Medicaid (if applicable): • Medicaid card or evidence of rejection *If the service is for your child or you are developmentally disabled, and have not applied for Medicaid, we can help you in this area. Please let our office staff know.*	☐	☐
Medicare (if applicable): • Medicare card	☐	☐

** Indicates a mandatory submission of these documents
** If services are for your child, we will require proof of Medicaid rejection. If we feel you may qualify for Medicaid funded services for your child, we can help you access this benefit.

Schedule of Income Thresholds Based upon 2016 Federal Poverty Guidelines

Annual Basis

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level	**At or Below 100%**	**125%**	**150%**	**175%**	**200%**	**>200%**
Family Size	**Percentage of Charges**					
	Nominal Fee $5.00	**20%**	**40%**	**60%**	**80%**	**100%**
1	$ 11,880.00	$ 14,850.00	$ 17,820.00	$ 20,790.00	$ 23,760.00	$ 23,761.00
2	$ 16,020.00	$ 20,025.00	$ 24,030.00	$ 28,035.00	$ 32,040.00	$ 32,041.00
3	$ 20,160.00	$ 25,200.00	$ 30,240.00	$ 35,280.00	$ 40,320.00	$ 40,321.00
4	$ 24,300.00	$ 30,375.00	$ 36,450.00	$ 42,525.00	$ 48,600.00	$ 48,601.00
5	$ 28,440.00	$ 35,550.00	$ 42,660.00	$ 49,770.00	$ 56,880.00	$ 56,881.00
6	$ 32,580.00	$ 40,725.00	$ 48,870.00	$ 57,015.00	$ 65,160.00	$ 65,161.00
7	$ 36,730.00	$ 45,913.00	$ 55,095.00	$ 64,278.00	$ 73,460.00	$ 73,461.00
8	$ 40,890.00	$ 51,113.00	$ 61,335.00	$ 71,558.00	$ 81,780.00	$ 81,781.00
For each additional household member add:	$ 4,160.00	$ 5,200.00	$ 6,240.00	$ 7,280.00	$ 8,320.00	$ 8,320.00

To be completed by Testing and Counseling Center Staff:

☐ Client is eligible for sliding fee discount in the amount of $_____________________ or __________________% reduction.

☐ Proof of Income Verified
☐ Client refused to complete
☐ Client does not qualify for sliding fee

____ ________________________

Completed By Date