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:	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			

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.

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	**$**

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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 and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Innovative Health Care Concepts, Inc. 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 Innovative Health Care. I hereby acknowledge that I read the foregoing disclosure and understand it.

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 not be considered for discount.

Verification Checklist **Attach copies of each item checked below**	**Yes**	**No**
*Identification/Address (Submit one of the following): • Driver's license, or • Birth certificate, or • Social Security Card, or • Other: _____	☐	☐
*Income: • Prior year tax return, or • **Three** most recent pay stubs, or • W-2 or 1099, Form4506-T, or • Other: _____	☐	☐
Insurance (if applicable): • Insurance card(s)	☐	☐
Medicaid (if applicable): • Medicaid card or evidence of rejection *You may be eligible for Medicaid benefits. Please let our office staff know and we may be able to help you with this process.*	☐	☐
Medicare (if applicable): • Medicare card	☐	☐

* Indicates a mandatory submission of these documents

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Schedule of Income Thresholds Based upon 2020 Federal Poverty Guidelines

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	**At or Below 100%**	**125%**	**150%**	**175%**	**200%**	**Above 200%**
	Charge					
Family Size	**Nominal Fee ($5)**	**20% pay**	**40% pay**	**60% pay**	**80% pay**	**100% pay**
1	0-$12,760	12,761-15,950	15,951-19,140	19,141-22,330	22,331-25,520	25,521+
2	0-$17,240	17,241-21,550	21,551-25,860	25,861-30,170	30,171-34,480	34,481+
3	0-$21,720	21,721-27,150	27,151-32,580	32,581-38,010	38,010-43,440	43,441+
4	0-$26,200	26,201-32,750	32,751-39,300	39,301-45,850	45,851-52,400	52,401+
5	0-$30,680	30,681-38,350	38,351-46,020	46,021-53,690	53,691-61,360	61,361+
6	0-$35,160	35,161-43,950	43,951-52,740	52,741-61,530	61,531-70,320	70,321+
7	0-$39,640	39,641-49,550	49,551-59,460	59,461-69,370	69,371-79,280	79,281+
8	0-$44,120	44,121-55,150	55,151-66,180	66,181-77,210	77,211-88,240	88,241+
For each additional person, add	$4,480	$5,600	$6,720	$7,840	$8,960	$8,960

To be completed by Innovative Health Care Staff:

Client Name:_____ DOB: _____

- ❑ Client is not eligible for Sliding Fee Discount Program based on income verification provided
- ❑ Client is eligible for sliding fee discount in the amount of $_____ or _____% reduction.
  ☐ Proof of Income Verified

Verification completed by (please print): _____

_____ _____

Signature Date