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	**$**

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 • **<u>Three</u>** 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.

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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 250%**
	Charge					
Family Size	**Nominal Fee ($5)**	**20% pay**	**40% pay**	**60% pay**	**80% pay**	**100% pay**
1	0-$12,760	15,950	19,140	22,330	25,520	31,900+
2	0-$17,240	21,550	25,860	30,170	34,480	43,100+
3	0-$21,720	27,150	32,580	38,010	43,440	54,300+
4	0-$26,200	32,750	39,300	45,850	52,400	65,500+
5	0-$30,680	38,350	46,020	53,690	61,360	76,700+
6	0-$35,160	43,950	52,740	61,530	70,320	87,900+
7	0-$39,640	49,550	59,460	69,370	79,280	99,100+
8	0-$44,120	55,150	66,180	77,210	88,240	110,300+
For each additional person, add	$4,480	$5,600	$6,720	$7,840	$8,960	$11,200

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