# Sliding Fee Discount Application

Date: _____
Patient Name: _____
Patient Date of Birth: _____
Guarantor/Patient#: _____

To be qualified for a sliding fee discount, a patient must provide family size. A family is defined as all current people living within a household who are related by birth, marriage, adoption, or other living arrangements who live together at least 50% of the time and/or are supported by the income for that family. Also included are family members living outside the household who are contributing to or supported by the family, i.e., in military service, migrant worker, oil field workers, etc. Family size is determined by patient declaration.

Family Size: _____ Names of dependents covered by this application:
_____
_____

PROOF OF INCOME MUST BE PROVIDED from all eligible sources, for all household members. See back of this form for items to include in income and what to exclude.

Family's income from all family members and all sources

Every two weeks _____ Monthly _____ Annual/yearly _____

I have read the above, and declare the information furnished by me to be true and complete to the best of my knowledge. I will notify Health West of any changes in my income, resources, or family size. I also understand that this information will be treated in a confidential manner in accordance with State and Federal Law.

☐ ***By checking this box, I acknowledge that I wish to decline at this time.***

Signature of the Requestor _____ _____
Date

Verified By Staff Member _____ _____
Print name and Signature Date

Applicant is eligible for Slide (select one only): ☐ A ☐ B ☐ C ☐ D ☐ E
Proof has been provided: ☐ Yes ☐ No
This application will expire one year from the approval date: _____

*** Attach the proof of income provided as support for this request*

See FI-005 Sliding Fee Scale, Nominal Fee, and Fee Waivers; Documentation of Eligibility in Policy Tech for more information on the use of this form.

Once approved the form needs to be attached in Athena to the patient's account.

To be qualified for a sliding fee discount, a patient must provide proof of income from all eligible sources, for all household members. Proof of income includes:

- Most recent pay stub that shows gross pay
- Signed Income Verification Letter form from employer stating wages
- Most recent signed 1040 tax return and/or all W-2's for the prior year
- Public Assistance award letter (food stamps, temporary assistance, Public Housing)
- Medicaid eligibility letter with income
- Head Start award letter
- Income statement from dividends, interest, and/or rent
- Social Security Income (SSI) statement
- Disability Income (SSDI) statement
- Retirement income statement
- Unemployment compensation statement
- Pension statement
- Workman's Compensation
- Veteran's Benefit
- Work projection letter from Idaho Department of Labor
- Letter from sponsor or other affiliated organization stating income (SEICCA, WIC, Homeless Shelter, etc.)
- **Annual Self-Declaration of Income Form**: Signed Self-Declaration Form is used as a last resort to state income or unemployment (requires a Patient Resource Coordinator or Clinic Administrator approval)
- Other forms of documentation must be approved by the Chief Financial Officer or Revenue Cycle Manager. Documentation of approval should be noted on the Sliding Fee Discount Application.
- **The following items will not be counted as income, if this is the patient's only source of support, they would complete the Annual Self Declaration of Income Form**
    - · Child support
    - · School grants and loans
    - · Loan proceeds
    - · Tax refund
    - · Rebates
    - · Expense reimbursements