



Sliding Fee Discount Application

Patient Name: _____

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

To qualify for a sliding fee discount, the 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 supporting the family (i.e., military service, seasonal worker, oil field worker, etc.) Family size is determined by patient declaration.

Family Size: _____

Name(s) of dependent(s) covered by this application:

PROOF OF INCOME MUST BE PROVIDED from all eligible sources for all household members. See back of form for acceptable proof of income sources.

Pay frequency of family income (from all family members and all sources):

Bi-Weekly (every two weeks): _____ Monthly: _____ Annually (yearly): _____

I have read the above, and declare the information provided 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, and/or family size. I also understand that this information will be treated in a confidential manner in accordance with state and federal law.

Decline. *By checking this box, I acknowledge that I wish to withdraw this application.*

Requestor Signature: _____ Requested Date: _____

Approver Signature: _____ Approval Date: _____

For Health West Staff Only:

Slide Eligibility: A Slide B Slide C Slide D Slide E Slide

Proof of Income Provided: Yes No

Type of Income Source (**attach copy to form**): _____

To qualify for a sliding fee discount, the patient **must** provide a copy of proof of income from an eligible source for all household members, such as:

- Most recent pay stub that shows gross pay
- Signed Income Verification Letter from employer, stating wages
- Most recent signed 1040 Tax Return and/or all W-2's for prior year
- Public Assistance award letter (e.g., food stamps, temporary assistance, public housing)
- Medicaid eligibility letter that states 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 (e.g., SEICCA, WIC, Homeless Shelter, etc.)
- **Annual Self-Declaration of Income Form:** The Self-Declaration Form should be used as a last resort to state income or unemployment. This form needs to be signed by the patient and will require a Patient Resource Coordinator or Clinic Administrator approval.
- **Other forms of documentation:** must be approved by the Director of Revenue Cycle or Chief Financial Officer. Documentation for approval should be noted on the Sliding Fee Discount Application.

The following items are **not** an acceptable proof of income source:

- Child support
- School grants and loans
- Loan proceeds
- Tax refund
- Rebates
- Expense reimbursements

Refer to FI-005 Sliding Fee Scale, Nominal Fee, and Fee Waivers; Documentation of Eligibility for more information