**Sliding Fee Discount Program Application**

* No one will be denied care due to inability to pay.
* Sliding fee discounts are available to patients only based on INCOME and FAMILY SIZE, and no other factors
* We will backdate eligibility for discounts if you bring the required documentation within 45 days of the visit.
* You must reapply yearly for the Sliding Fee Discount Program to be reassessed for eligibility.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_

Please list all individuals, including yourself, that meet one of the following criteria:

• All individuals that can be claimed by guarantor on Federal or State income tax returns • All individuals, who may or may not live together, who share gross income

|  |  |  |  |
| --- | --- | --- | --- |
| Family Members | Relationship | Date of Birth | IFHC Acct #:  (Office Use Only) |
|  | Self |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

IFHC uses IRS Federal Tax Return Total Income as a guideline for income determination plus additional items listed below.

Please list yearly amount for any income item that applies to you:

|  |  |
| --- | --- |
| Income Category | Yearly Amount |
| Wages, salaries, tips and etc. |  |
| Interest, dividends |  |
| Taxable refunds, credits, or offset of state and income taxes |  |
| Alimony received |  |
| Self-employment, business income |  |
| Capital Gains, other gains |  |
| Retirement |  |
| Pensions and annuities |  |
| Rental income, trusts and etc |  |
| Farm income |  |
| Unemployment |  |
| Social Security Benefits |  |
| Any Other Income |  |
| Supplemental Security Income (SSI) |  |
| Any cash public assistance or welfare payments from the state or local welfare office |  |
| Veteran’s (VA) payments |  |
| Workers Compensation |  |
| Child support received |  |

The following items will reduce your income. Please list the yearly amount for any item that applies to you:

|  |  |
| --- | --- |
| Income Category | Yearly Amount ($$) |
| Alimony paid |  |
| Child support paid |  |

The following documentation are acceptable for verification of income or change of income. Please provide any documentation from the list below to support your income.

|  |
| --- |
| Income Acceptable Documentation |
| Most recent Federal Tax Returns |
| The two most current paycheck stubs |
| Most current year W2 |
| Letter from employer |
| Public assistance verification letter |
| Unemployment checks or letters from unemployment office |
| Social Security Statement |
| Copy of checks or bank statements that prove the income (VA, Child Support (2 most recent payments or receipts), Alimony etc.) |
| If self-employed, details of the most recent three months of income and expenses for the business |

• My signature below authorizes the IFHC to release my financial information to Benefis Health Systems or any other medical institution to assist in determining a discount at those institutions.

• I understand that I may be prosecuted under applicable state or federal laws for giving fraudulent information to obtain discounted services at IFHC.

• By signing this form, I affirm that all information given is an accurate income statement at the time of this application.

Signature of Applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only:**

Date of application received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Slide Fee Discount Program Eligibility Effective Date (the earliest appointment date within 45 days from application received date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Dependents: \_\_\_\_\_\_\_\_\_ Yearly Income: \_\_\_\_\_\_\_\_\_\_\_\_ Income Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_