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# Financial Interview/Sliding Fee Waiver Form

Return to: Reviewed by: Date Reviewed:

## TO BE COMPLETED BY PERSON RESPONSIBLE FOR BILL

The information requested is to allow us to assist you in establishing a reasonable payment program and is confidential. You must provide us with complete information to enable us to determine how we can help you.

### *\*\*\*If client requesting sliding fee waiver; must fill out additional worksheet on page 3*

*\*\*\*Every Co-Occurring Client must complete this form regardless of financial need; must be filed in client’s chart.*

### CLIENT

Name SSN DL # DOB

 (last, first, middle)

Address Phone

 (street, city, state, zip)

Work Phone Ext

Are you disabled? If yes, disability

### RESPONSIBLE PARTY (if different from client)

Name SSN DL # DOB

 (last, first, middle)

Address Phone

 (street, city, state, zip)

Work Phone Ext

Are you disabled? If yes, disability

### HOUSEHOLD INFORMATION (include information about everyone who lives with you, starting with the client on the first line)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name**  | **Relationship to client** | **Date of birth** | **Gender** **(M or F)** | **Social Security Number** | **Marital Status** **S=single****M=married****D=divorced****W=widowed** | **MT Resident?****Y or N** | **Dependent?** **Y or N** |
|  | Client |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |

Is any person(s) listed in your household 22 years or younger and attending a college, university of vocational/technical school?

Yes \_\_\_\_ No \_\_\_\_\_

If yes, please complete: Name of Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### HOUSEHOLD INCOME \* *Please attach copies of most recent Federal Tax Return.*

**A: Income received from employment**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of household member | Employer | Start Date | Average hrs. work/week | Pay/wages per hour | If tip income earned, amount of tips/year | Is this job seasonal? If yes, number of weeks or months worked.  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**B: Income received through other sources or through self-employment**

List all unearned income received by all household members, including children. Unearned income includes, but is not limited to, Social Security, Disability, Unemployment Insurance, Pensions, Military Allotments, Child Support, Alimony, Lease or Rental Income, Supplemental Security Income (SSI), Foster Care Payments, Veteran’s Benefits, Retirement Income, Tribal Assistance Payments, Dividends, Interest, Temporary Disability.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of household member** | **Type of Income** | **Source of Income** | **How often is income received (weekly, monthly)** | **Amount received** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

### INSURANCE

Is the above client covered by Medicaid insurance? Yes\_\_\_\_\_ No\_\_\_\_\_

May the client financially qualify for Medicaid? Yes\_\_\_\_\_ No\_\_\_\_\_

Is the above client covered by any insurance through an employer or private plan? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, include insurance information here:

Carrier:

Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Pay amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### ADDITIONAL INFORMATION

Attach verification of income and major expenses from the last 90 days.

Please list any other financial conditions which should be considered in establishing a payment plan:

I hereby authorize representatives of Intermountain to make whatever inquiries necessary to verify the information furnished on this form or to release any information regarding this hospitalization to any insurance company or third party to seek settlement of this account. I hereby state that to the best of my knowledge the information given above is true and complete. I further authorize Intermountain to review and/or inquire into my credit history using any means available to obtain a current Credit Bureau History Report.

Signature of Responsible Party Date Signature of Spouse Date

**When form completed turn into the Chief Business Officer**

**Business Office Use Only**

Notes from meeting with family:

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approved Discount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Amount of Payment per month to go into contract: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
|  **Verification Checklist Yes No**  |
| **Identification/Address: Driver’s license, utility bill, employment ID, or other** |  |  |
| **Income: Prior year tax return, three most recent pay stubs, or other** |  |  |
| **Insurance: Insurance Cards** |  |  |