Sliding Fee Application

It is the policy of Intermountain to provide affordable and quality services. The Sliding Fee Discount Program is designed to help those who are uninsured or underinsured and who meet specific guidelines. The discount is based on family size and income at or below 300% of the Federal Poverty Guideline (FPG) and allows you and your family to pay a reduced fee for outpatient services received at Intermountain excluding prescribed medication, incomplete Psychological and Neuropsychological Assessment and Testing due to failure to complete testing, and educational courses. For educational courses a discount is offered for those below 200% of the FPG.

Eligibility for the program is determined by documented annual income and family/household size. Documentation of all disclosed income and deductions must be received within two (2) weeks of this dated application. If the documentation is not provided within that time frame the application will be re-dated to the date on which the information is supplied.

If at any time during the application process you need assistance, please feel free to contact our Admissions Coordinator at 406-442-7920.

GENERAL INFORMATION ☐ New Application ☐ Change in Income ☐ Renewal

CLIENT INFORMATION

_____ _____-_____-_____ _____/_____/_____
Client First Name MI Last Name Social Security # Date of Birth

RESPONSIBLE PARTY

_____ _____-_____-_____ _____/_____/_____
First Name MI Last Name Social Security # Date of Birth

_____-_____-_____ _____
Primary Phone # Mailing Address City State Zip

_____ _____-_____-_____
Name of Employer Work #

HOUSEHOLD INFORMATION—List ALL members of your household.

Name	Relationship to Client	DOB	SS #	Marital Status *	Dependent (Y or N)
	CLIENT				

***Marital Status: S-Single, M-Married, D-Divorced, W-Widowed**

INSURANCE

Is the client covered by Medicaid Insurance? ☐ **Yes** ☐ **No** If NO, has the client applied for Medicaid? ☐ **Yes** ☐ **No**

If YES, has the client received a denial letter**?** ☐ **Yes** ☐ **No** If NO, does the client financially qualify**?** ☐ **Yes** ☐ **No**

Is the client covered by any insurance plan**?** ☐ **Yes** ☐ **No** ***If yes please confirm information is in Credible.**

If you have not applied for Medicaid and/or could be eligible, please apply online at https://apply.mt.gov or call the Office of Public Assistance for questions about applications and/or eligibility at 1-888-706-1535. A Medicaid processed application or denial letter (stating reason for denial) is required if not covered by insurance. (*Please attach denial letter to application*.)

Does any member of the household report a decrease in income or no income at this time? ☐ Yes ☐ No
If Yes, a Statement of Zero Income must be completed by each of those household members.

HOUSEHOLD INCOME—List all household members that are expected to file a tax return. Dependents with earned income more than $6,300 must file a tax return. Include full-time, part-time, and seasonal employment, temporary or spot jobs, tips, and commissions. For self-employment state average monthly income.

Name of Household Member	Employer	Avg. Hours Per Week	Hourly Wage and/or Salary Wage	Tip or Commission Income Earned Per Week	# of Weeks Worked Per Year (Seasonal)	Gross Per Year

OTHER HOUSEHOLD INCOME—List all unearned income received by all household members. Dependents with unearned income more than $1,050 must file a tax return. Unearned income includes; but is not limited to, Social Security Disability Income (SSDI), Rental Income, Unemployment Benefits, Veteran's Retirement, Pensions, Alimony Received, Lease/Rental Income, Dividends, Interest.

Name of Household Member	Type of Income	Source of Income	How often is income received (weekly/monthly)	Amount Received Per Year

NOTE: Documentation of income will need to be provided before a discount is approved. Please attach documentation to application.

EXCLUSIONS—Child support received, gifts and inheritance, Worker's Compensation, Veteran's Benefits, Military Allotments, Scholarships or Grants used for Educational Purposes (some Native American income, SSI Benefits, Welfare & Public Assistance Payments, Foster Care Payments, Adoption Subsidies. ***Verification may be required***.

DEDUCTIONS—The following deductions can include; Alimony paid, Pre-Tax Contributions (401K, Flex, HSA, Health Insurance), Medical Expenses (above 10% of MAGI), Tuition and Fees, Student Loan Interest, Moving Expenses.

Name of Household Member	Deduction Type	Source	Yearly Amount

NOTE: Documentation of deductions and exclusions may be required before a discount is approved. Please attach documentation to application.

Total # in Household: _____

Total Gross Household Income: $ _____

Total Unearned Income: + _____

Total Deductions: - _____

Modified Gross Adjusted Income (MAGI) = _____

FEDERAL POVERTY GUIDELINES—For each additional person add $4,480.00.

Family Size		125%	150%	175%	200%	300%
1	12,760	15,950	19,140	22,330	25,520	38,280
2	17,240	21,550	25,860	30,170	34,480	51,720
3	21,720	27,150	32,580	38,010	43,440	65,160
4	26,200	32,750	39,300	45,850	52,400	78,600
5	30,680	38,350	46,020	53,690	61,360	92,040
6	35,160	43,950	52,740	61,530	70,320	105,480
7	39,640	49,550	59,460	69,370	79,280	118,920
8	44,120	55,150	66,180	77,210	88,240	132,360
Discount	**100%**	**100%**	**95%**	**90%**	**85%**	**50%**
Monthly Minimum Payment	**N/A**	**N/A**	**10.00**	**15.00**	**20.00**	**25.00**
Education Courses	**50%**		**25%**		**No Discount**	

Federal Poverty Guidelines 2020: https://aspe.hhs.gov/poverty-guidelines

ADDITIONAL INFORMATION: Please state any additional information or extenuating circumstances you feel may be helpful when we review the application for the Sliding Fee Discount Program.

- I certify that the information provide on this application is true, complete and accurate.
- I will provide documentation for all income and deductions as disclosed on the application. I understand that I must provide documentation within two (2) weeks of this dated application. If the documentation is not provided within that time frame the application will be re-dated to the date on which the information is supplied.
- I understand that the Sliding Fee Discount Program application covers outstanding balances for six months prior and any balances incurred within 12 months after the approval date.
- I understand that I must report significant changes to insurance, income (e.g., loss of employment, obtain employment), or family size.
- I understand any accounts turned over for collection as a result of my delay in providing information will not be considered for the Sliding Fee Discount Program.
- My signature authorizes Intermountain to confirm income as disclosed on the application. I understand that providing information subsequently determined to be false will result in all discounts being revoked and the full balance of the account(s) restored and payable immediately.

_____ _____/_____/_____

Responsible Party Signature Date Signed

_____ _____/_____/_____

Signature of Reviewer Date Signed

OFFICE USE ONLY:

☐ Approved ☐ Denied

Approved for: _____% of Fees Denied Letter Sent: _____/_____/_____

Effective: _____/_____/_____ Reason for Denial: ☐ Incomplete Application

☐ Exceeded income guidelines.

☐ Documentation not submitted.

_____

Signature of Approver