Sliding Fee Application

The Sliding Fee Discount Program is designed to minimize financial barriers to those with no means, or limited means to pay for their services (uninsured or underinsured). 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. 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 (pay-stub, verification letter, statement, copy of last Federal Tax Return) 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 Revenue Cycle Manger at 406-442-7920.

GENERAL INFORMATION ☐ New Application ☐ Change in Income ☐ Renewal

CLIENT INFORMATION

_____ _____
Client First Name MI Last Name Date of Birth

RESPONSIBLE PARTY

_____ _____
First Name MI Last Name 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
	CLIENT	

INSURANCE / ZERO INCOME - If you have not applied for MT Medicaid or HMK Plus and 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.

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/card is in Credible.**

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 householder 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 Income, Public Assistance (including Food Stamps), Child Support Received, Unemployment Benefits, Retirement/Pension, 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.

DEDUCTIONS—The following deductions can include: Pre-Tax Contributions (401K, Flex, HSA, Health Insurance), Medical Expenses (above 10% of MAGI). ***Verification may be required***.

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 $4,450.00.

Family Size		125%	150%	175%	200%	300%
1	12,880	16,100	19,320	22,540	25,760	38,640
2	17,420	21,775	26,130	30,485	34,840	52,260
3	21,960	27,450	32,940	38,430	43,920	65,880
4	26,500	33,125	39,750	46,375	53,000	79,500
5	31,040	38,800	46,560	54,320	62,080	93,120
6	35,580	44,475	53,370	62,265	71,160	106,740
7	40,120	50,150	60,180	70,210	80,240	120,360
8	44,660	55,825	66,990	78,155	89,320	133,980
Discount	**Nominal Fee $5.00**	**Nominal Fee $10.00**	**85%**	**80%**	**75%**	**40%**
Monthly Minimum Payment	**10.00**	**15.00**	**30.00**	**40.00**	**50.00**	**100.00**
Education Courses	**50%**		**25%**		**No Discount**	

Federal Poverty Guidelines 2021: 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 Denial Letter Sent: _____

Effective: _____ Reason for Denial: ☐ Incomplete Application

☐ Exceeded income guidelines.

☐ Documentation not submitted.

_____

Signature of Approver