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 (two most recent paystubs, statement of zero income, copy of prior year W-2 (or Form 4506-T)) 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 the information is supplied.

If at any time during the application process you need assistance, please feel free to contact our billing team 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 | Zip | 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.

Are you covered by Medicaid? ☐ Yes ☐ No

- If yes, please ensure Intermountain has received a copy of your insurance card for billing purposes.

Are you covered by an insurance plan other than Medicaid? ☐ Yes ☐ No

- If yes, please ensure Intermountain has received a copy of your insurance card for billing purposes.

Does any member of the household report a change in income or no income currently? ☐ Yes ☐ No

- If yes, please submit income documentation.

HOUSEHOLD INCOME—List all household members that are expected to file a tax return, including dependents with earned income more than $6,300. Include full-time, part-time, and seasonal employment, temporary or spot jobs, tips, and commissions. For self-employment, state the 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, including dependents with unearned income more than $1,050. 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 may need to be provided before a discount is approved. Please attach documentation to the application.

DEDUCTIONS—Please list everything that reduces your income when you are filing your taxes (for example: medical expenses, 401K contributions, HSA, etc)

Name of Household Member	Deduction Type	Source	Yearly Amount

Total # in Household: ________

Total Gross Household Income: $ ________________

Total Unearned Income: + ________________

Total Deductions: - ________________

Modified Gross Adjusted Income (MAGI) = ________________

FEDERAL POVERTY GUIDELINES—For families/households with more than 8 persons, add $5,380 for each additional person.

Family Size	100%	125%	150%	175%	200%	300%
1	15,060	18,825	22,590	26,355	30,120	45,180
2	20,440	25,550	30,660	35,770	40,880	61,320
3	25,820	32,275	38,730	45,185	51,640	77,460
4	31,200	39,000	46,800	54,600	62,400	93,600
5	36,580	45,725	54,870	64,015	73,160	109,740
6	41,960	52,450	62,940	73,430	83,920	125,880
7	47,340	59,175	71,010	82,845	94,680	142,020
8	52,720	65,900	79,080	92,260	105,440	158,160
Discount	**Nominal Fee 5.00**	**Nominal Fee 10.00**	**85%**	**80%**	**75%**	**40%**
Monthly Minimum Payment	**0.00**	**15.00**	**30.00**	**40.00**	**50.00**	**100.00**
Education Courses	**50%**		**25%**		**No Discount**	

Federal Poverty Guidelines 2024: 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.

Acknowledgement:

- I certify that the information provided 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

OFFICE USE ONLY:

☐ Approved – Effective: ______________ ☐ Denied - Denial Letter Sent: ______________

_______% of Fees Reason for Denial: ☐ Incomplete Application

$_______ per service ☐ Exceeded income guidelines.

Re-application date: ______________ ☐ Documentation not submitted.

______________________________________ ______________

Billing Signature Date Signed