Sliding Fee Discount Program Application

It is the policy of the Pocatello Children's Clinic to provide medically necessary services regardless of the patient's ability to pay. Discounts are offered based upon household income and size. Please complete the following information and return to the front desk with the following *required documentation*: *Identification* (Driver's License, State ID Card), *Proof of Residency* (Utility Bill, Lease Agreement), *Income* (Prior Year Tax Return, 3 most Recent Pay Stubs & Verification of any Additional Income) and *Insurance* (Copies of valid Insurance Cards, Medicaid Application or Evidence of Valid Rejection). We will then be able to determine if you or members of your family are eligible for a discount.

The discount will apply to all medically necessary Pocatello Children's Clinic charges, in the clinic or hospital, but not to services purchased from outside, including reference lab testing, medications, x-ray interpretation, charges from the hospital and other such services. Once approved, the discount will be honored for the 90 days prior to the application date and any balances incurred within 180 days of the application date, unless your financial situation changes significantly. This form must be completed every 180 days or if your financial situation changes. Please inquire at the front desk if you have questions.

Name of Head of Household: _____ Phone: _____

Address: _____ City: _____ ST _____ Zip _____

Health Insurance Plan: _____ Policy #: _____

Place of Employment: _____

Social Security Number: _____

Number of related persons living in your household: _____

Please list all related persons living in your household:

Name	Date Of Birth	Name	Date of Birth
Self		**Dependent**	
Spouse		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, pension, disability, workers compensation, Supplemental Security Income, public assistance, unemployment compensation, survivor benefits, retirement income or veteran's benefits				
Income from alimony, child support, military family allotments, estates, trusts, or educational assistance.				
Income from business, self-employment & dependents				
Rents, interest, dividends, annuities, royalties, assistance from outside the household and other miscellaneous sources.				
Total Income				

I certify that the family/household size and annual income information above is correct.

Name (print): _____ Date: _____

Signature: _____

NOTE: Additional copies of tax returns, pay stubs and other information verifying income may be required before a discount is approved.

Office Use only

Patient Name: _____ Discount: _____

Date of Service: _____ Approved by: _____

Verification Checklist (attached copies)	Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, three most recent pay stubs, other		
Insurance: Insurance card (s)		
Medicaid: Application made or evidence of rejection		