SLIDING FEE DISCOUNT APPLICATION

It is the policy of InterMountain Medical Clinic to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed at least annually or if your financial situation changes.

***PATIENT NAME: ____ *PATIENT DOB: ____________________**

***How many people are dependent on your family income?** 1 2 3 4 5 6 7 8 8+ ____ indicate additional.

***Please list spouse and dependents under age 18:**

NAME:	DOB:	NAME:	DOB:
SELF:		DEPENDENT:	
SPOUSE:		DEPENDENT:	
DEPENDENT:		DEPENDENT:	
DEPENDENT:		DEPENDENT:	

HOUSEHOLD INCOME MUST INCLUDE:

SALARY, WAGES, TIPS, BUSINESS PROFITS, ALIMONY, CHILD SUPPORT, SIGNIFICANT OTHER, RELATIVE, FRIENDS, RETIREMENT FUND/ SAVINGS, PENSIONS, SOCIAL SECURITY, SSDI, PUBLIC ASSIST. WELFARE, VETERAN'S ADMIN. UNEMPLOYMENT COMP., OR OTHER INCOME

ANNUAL GROSS HOUSEHOLD INCOME (please check one)

____$0 - $10,000
____$10,000 - $20,000
____$20,000 - $30,000
____$30,000 - $40,000
____$40,000 - $50,000
____$50,000 - $60,000
____$60,000 - $70,000
____$70,000 or above

***What is your Family's Total GROSS Income? $_______________Monthly or $_____________Yearly**

____**I WISH TO DECLINE AT THIS TIME:**

SIGNATURE: ____DATE: ________________

If you wish to qualify for the sliding fee, you MUST show proof of income for ALL family members/individuals living in your household or individuals for whom you are financially responsible. Applicants should provide a copy of:

- Three consecutive pay stubs for each employed adult age 18 and over living in the household, or living outside the household but for whom the household is financially responsible
- Previous year's tax return including supporting documents (ex. W-2/1099) for each adult living in the household or for whom the household is financially responsible.
- Proof of other income such as SSDI, child support/alimony, unemployment compensation, social security, welfare, retirement fund/savings, business profits, etc. If you do not have any source of income, please speak with a staff member.

I have read the above, and declare the information furnished by me to be true and complete to the best of my knowledge. I will notify InterMountain Medical Clinic of any changes in my income, resources or family size. I also understand that this information will be treated in a confidential manner in accordance with State and Federal Law.

SIGNATURE: ____ DATE: _________________________

IF above information isn't provided by ___________________ application will be denied.

____ DATE: _______________________________
Verified by IMMC Staff member

OFFICE USE ONLY:

Proof has been provided? Y N

W-2/1099 Federal Tax Return Wage Stub(s) Other: ________________________

Applicant is eligible for ______% discount.

Applicate is ineligible due to:

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