205 North Berkley – Council Idaho 83612 - Phone: 208-253-4242 - FAX: 208-253-6849

RETURN FORMS TO: PO BOX 428 COUNCIL, ID 83612

ATTENTION SLIDING FEE PATIENTS

ALL SLIDING FEE PATIENTS ARE REQUIRED TO PAY YOUR NOMINAL CHARGE/MINIMUM PAYMENT AT THE TIME SERVICE IS PROVIDED.

SLIDING FEE DISCOUNTS (SFD) APPLY ONLY TO ORDERS OR SERVICES, WRITTEN AND RENDERED, BY ADAMS COUNTY HEALTH CENTER INC. IN-HOUSE PROVIDERS.

ADAMS COUNTY HEALTH CENTER INC.

2020 Sliding Fee Discount Program Schedule

ANNUAL INCOME[1] – Thresholds by Sliding Fee Discount Pay Class and Percentage of Poverty

ANNUAL INCOME												
Category		1		2		3		4		5		
Charge		Nominal Charge (N.C)		N.C + 20% of Charge		N.C + 40% of Charge		N.C + 60% of Charge		N.C + 80% of Charge		100%
FPG		At or Below 100%		101-125%		126-150%		151-175%		176-200%		Over 200%
Pharmacy Fee		Cost + $3.00		Cost + $4.00		Cost + 5:00		Cost + $6.00		Cost + $7.00		
household size	1	$0	$12,760	$12,761	$15,950	$15,951	$19,140	$19,142	$22,330	$22,331	$25,520	>$25,521
	2	$0	$17,240	$17,241	$21,550	$21,551	$25,860	$25,861	$30,170	$30,171	$34,480	>$34,481
	3	$0	$21,720	$21,721	$27,150	$27,151	$32,580	$32,581	$38,010	$38,011	$43,440	>$43,441
	4	$0	$26,200	$26,201	$32,750	$32,751	$39,300	$39,301	$45,850	$45,851	$52,400	>$52,401
	5	$0	$30,680	$30,681	$38,350	$38,350	$46,020	$46,021	$53,690	$53,691	$61,360	>$61,361
	6	$0	$35,160	$35,161	$43,950	$43,951	$52,740	$52,741	$61,530	$61,531	$70,320	>$70,321
	7	$0	$39,640	$39,641	$49,550	$49,551	$59,460	$59,461	$69,370	$69,371	$79,280	>$79,281
	8	$0	$44,120	$44,121	$55,150	$55,151	$66,180	$66,181	$77,210	$77,211	$88,240	>$88,241
Note: for families/households with more than 8 persons, add $4,480 for each additional person												

MONTHLY INCOME – Thresholds by Sliding Fee Discount Pay Class and Percentage of Poverty

MONTHLY INCOME												
Category		1		2		3		4		5		
Charge		Nominal Charge (N.C)		N.C + 20% of Charge		N.C + 40% of Charge		N.C + 60% of Charge		N.C + 80% of Charge		100%
FPG		At or Below 100%		101-125%		126-150%		151-175%		176-200%		Over 200%
Pharmacy Fee		Cost + $3.00		Cost + $4.00		Cost + 5:00		Cost + $6.00		Cost + $7.00		
household size	1	$0	$1,063	$1,064	$1,329	$1,330	$1,595	$1,596	$1,861	$1,862	$2,127	>$2,128
	2	$0	$1,437	$1,438	$1,796	$1,797	$2,155	$2,156	$2,514	$2,515	$2,873	>$2,874
	3	$0	$1,810	$1,811	$2,263	$2,264	$2,715	$2,716	$3,168	$3,169	$3,620	>$3,621
	4	$0	$2,183	$2,184	$2,729	$2,730	$3,275	$3,276	$3,821	$3,822	$4,367	>$4,368
	5	$0	$2,557	$2,558	$3,196	$3,197	$3,835	$3,836	$4,474	$4,475	$5,113	>$5,114
	6	$0	$2,930	$2,931	$3,663	$3,664	$4,395	$4,396	$5,128	$5,129	$5,860	>$5,861
	7	$0	$3,303	$3,304	$4,129	$4,130	$4,955	$4,956	$5,781	$5,782	$6,607	>$6,608
	8	$0	$3,677	$3,678	$4,596	$4,597	$5,515	$5,516	$6,434	$6,435	$7,353	>$7,354
Note: for families/households with more than 8 persons, add $373 for each additional person												

Service Category	Nominal Charge (>100% FPG)	Minimum Payment (101-200% FPG
Medical	$25	$25 plus % of Charge
Dental	$60	$60 plus % of Charge
Behavioral Health	$25	$25 plus % of Charge
Optometry	$60	$60 plus % of Charge
Lab	$25	$25 plus % of charge
X-ray	$25	$25 plus % of charge
Physical Therapy	$25	$25 plus % of charge
Pharmacy	Category 1	Category 2 – Category 5

2020 FPG published 1/15/2020 by the Federal Register for Health and Human Services https://aspe.hhs.gov/poverty-guidelines

Board Approval: 2019/07/31, 2020/1/22

FINANCIAL ASSISTANCE APPLICATION

ADAMS COUNTY HEALTH CENTER INC.

Date of Request	
Patient Name	
Mailing Address	
Physical Address	
Phone Number	
Number of Persons Residing in household	

Adams County Health Center Inc., (ACHC) defines a family household member as anyone including self, spouse, or partner; any dependent children under 18 years of age; and anyone within the residence that the head of household provides support for. Please list yourself and all members of your family you wish to include in your household size.

ACHC uses your monthly gross income or your annual gross income to determine eligibility for discounted services. The following documentation is required for eligibility. Approved proof of identity and income sources includes one or more of the following items:

- Adult identification; may include driver's license, identification card or social security card
- Minor identification: may include birth certificate, identification card or social security card
- Paycheck stubs with year-to-date information
- Most recent tax returns
- Bank statements
- Statement of income determinations from federal, state or local government (such as SSI letter)
- ACHC's *No Proof of Income Worksheet*
- ACHC's *Homeless Eligibility Application* with *No Proof of Income Worksheet*

Household Member Name	Date of Birth	Relationship to Applicant	Monthly Income
		Self	$
			$
			$
			$
			$
			$
			$
			$
		Total Family/Household Income	**$**

FINANCIAL ASSISTANCE APPLICATION, CONT.

I certify that the information given on this form and the provided income documentation is complete, true and correct. If I do not qualify for financial assistance, I agree to pay the outstanding balance in full, or set up payment arrangements. I agree and understand that any remaining balance not paid through financial assistance will be my responsibility. If account balances are not paid, I agree to pay the resulting collection charges, legal fees, and understand that access to Adams County Health Center Inc., services may be restricted. I understand that the financial assistance will expire one year or twelve (12) months on or before the date indicated below and I will be required to reapply. If there is a change in income, I will submit a new Financial Assistance Application. You will receive a letter in the mail stating eligibility.

Signature: ____

Date: ___________________________________

--------------------------------------To be completed by ACHC staff only-------------------------------------

Patient Has Qualified For the Following Discount						
☐ Does Not Qualify	☐ Category 1	☐ Category 2	☐ Category 3	☐ Category 4	☐ Category 5	☐ No Proof of Income

Financial Assistance Approved Until (Date): ____________________________

Thank you for choosing Adams County Health Center Inc., as your healthcare provider. Based on the category indicated on the face of this document, please see below for discount detail. If you have any questions regarding your discount, please contact Adams County Health Center Inc.'s Sliding Fee Coordinator at 208-2534242 ext. 1017.

	What Do I Owe?								
		Services							
	FPG	*Pharmacy*	*Medical*	*In-House Lab*	*In-House X-Ray*	*Behavioral Health*	*Physical Therapy*	*Dental*	*Optometry*
1	0-100%	Cost + $3.00	$25					$60	
2	101-125%	Cost + $4.00	$25 + 20% of charges					$60 + 20% of charges	
3	126-150%	Cost + $5:00	$25 + 40% of charges					$60 + 40% of charges	
4	151-175%	Cost + $6.00	$25 + 60% of charges					$60 + 60% of charges	
5	176-200%	Cost + $7.00	$25 + 80% of charges					$60 + 80% of charges	

HOMELESS ELIGIBILITY APPLICATION

ADAMS COUNTY HEALTH CENTER INC.

Patient Status *Check One*		**Date:**		**MR#:**	
	New Patient				
	Established Patient				
Name:					
Date of Birth:		**Social Security Number:**			
Phone:		**Marital Status:** *Check One*			
			[ ] Single	[ ] Divorced	
			[ ] Married	[ ] Widowed	

My present living conditions lack a fixed, regular, and adequate nighttime residence and I have primarily nighttime residence that is: *(Check One)*	
[ ]	A supervised publicly or privately-operated shelter designated to provide temporary living accommodation (including welfare hotels, congregate shelters, and transitional housing)
Specify Place:	
[ ]	A residence/that provides a temporary housing for individuals and their families.
Specify Place:	
[ ]	Another public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for individuals.
Specify Place:	

I certify that I am homeless and do not have the resources to obtain housing for the following reasons:

Board Approval: 2019/07/31, 2020/1/22

HOMELESS ELIGIBILITY APPLICATION, CONT.

I certify that the information given on this form is complete, true and correct. If found to be untruthful, I understand that access to Adams County Health Center Inc. may be restricted. I understand that the financial assistance will expire on the date listed on the Financial Assistance Application and I will be required to reapply. If there is a change in income, I will submit a new Financial Assistance Application.

Patient Signature: ____

Date: _________________________________

NO PROOF OF INCOME WORKSHEET

ADAMS COUNTY HEALTH CENTER INC.

Patient Status *Check One*		**Date:**		**MR#:**	
☐	New Patient				
☐	Established Patient				

Name:			
Date of Birth:		**Social Security Number:**	
Phone:		**Marital Status:** *Check One*	☐ Single ☐ Divorced ☐ Married ☐ Widowed

Have you applied for Medicare, Medicaid, Primary Care Network (PCN), or Children's Health Insurance Program (CHIP)? *(Check One)*	☐ **Yes** ☐ **No**

Who provides financial support for you?	
Name:	
Relationship:	
Address:	
Phone Number:	

Patient Signature: ____

Date: ___________________________________

Board Approval: 2019/07/31, 2020/1/22

The following should be filled out by the person providing financial support OR self-declaration

Patient fees are based on the type of service provided and the patient's income and household size. If our patient has listed, you as the person who is financially supporting them. Please answer the following questions. If this is a self-declaration, please complete the statement below.

How long has the patient been living with you?	*Years*		*Months*	
How much financial support did you provide last month? (i.e., rent, utilities, food, etc.)				$
Provide a brief description of the situation:				

Patient or Supporter Signature: ____

Date: _______________________________

Board Approval: 2019/07/31, 2020/1/22