

**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.**

**2022 Sliding Fee Discount Program Schedule**

**ANNUAL INCOME[[1]](#footnote-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 + $16.50 | | Cost + $17.50 | | Cost + $18.50 | | Cost + $19.50 | | Cost + $20.50 | |  |
| household size | 1 | $0 | $13,590 | $13,591 | $16,988 | $16,989 | $20,385 | $20,386 | $23,783 | $23,784 | $27,180 | >$27,181 |
| 2 | $0 | $18,310 | $18,311 | $22,888 | $22,889 | $27,465 | $27,466 | $32,043 | $32,044 | $36,620 | >$36,621 |
| 3 | $0 | $23,030 | $23,031 | $28,788 | $28,789 | $34,545 | $34,546 | $40,303 | $40,304 | $46,060 | >$46,061 |
| 4 | $0 | $27,750 | $27,751 | $34,688 | $34,689 | $41,625 | $41,626 | $48,563 | $48,564 | $55,500 | >$55,501 |
| 5 | $0 | $32,470 | $32,471 | $40,588 | $40,589 | $48,705 | $48,706 | $56,823 | $56,824 | $64,940 | >$64,941 |
| 6 | $0 | $37,190 | $37,191 | $46,488 | $46,489 | $55,785 | $55,786 | $65,083 | $65,084 | $74,380 | >$74,381 |
| 7 | $0 | $41,910 | $41,911 | $52,388 | $52,389 | $62,865 | $62,866 | $73,343 | $73,344 | $83,820 | >$83,821 |
| 8 | $0 | $46,630 | $46,631 | $58,288 | $58,289 | $69,945 | $69,946 | $81,603 | $81,604 | $93,260 | >$93,261 |
| *Note: for families/households with more than 8 persons, add $4,720 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 + $16.50 | | Cost + $17.50 | | Cost + $18.50 | | Cost + $19.50 | | Cost + $20.50 | |  |
| household size | 1 | $0 | $1,133 | $1,134 | $1,416 | $1,417 | $1,699 | $1,700 | $1,982 | $1,983 | $2,265 | >$2,266 |
| 2 | $0 | $1,526 | $1,527 | $1,907 | $1,908 | $2,289 | $2,290 | $2,670 | $2,671 | $3,052 | >$3,053 |
| 3 | $0 | $1,919 | $1,920 | $2,399 | $2,400 | $2,879 | $2,880 | $3,359 | $3,360 | $3,838 | >$3,839 |
| 4 | $0 | $2,313 | $2,314 | $2,891 | $2,892 | $3,469 | $3,470 | $4,047 | $4,048 | $4,625 | >$4,626 |
| 5 | $0 | $2,706 | $2,707 | $3,382 | $3,383 | $4,059 | $4,060 | $4,735 | $4,736 | $5,412 | >$5,413 |
| 6 | $0 | $3,099 | $3,100 | $3,874 | $3,875 | $4,649 | $4,650 | $5,424 | $5,425 | $6,198 | >$6,199 |
| 7 | $0 | $3,493 | $3,494 | $4,366 | $4,367 | $5,239 | $5,240 | $6,112 | $6,113 | $6,985 | >$6,986 |
| 8 | $0 | $3,886 | $3,887 | $4,857 | $4,858 | $5,829 | $5,830 | $6,800 | $6,801 | $7,772 | >$7,773 |
| *Note: for families/households with more than 8 persons, add $393 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 |

**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?** | | | | | | | | |
|  | **FPG** | **Services** | | | | | | | |
| *Pharmacy* | *Medical* | *In-House Lab* | *In-House*  *X-Ray* | *Behavioral Health* | *Physical Therapy* | *Dental* | *Optometry* |
| 1 | 0-100% | Cost + $16.50 | $25 | | | | | $60 | |
| 2 | 101-125% | Cost + $17.50 | $25 + 20% of charges | | | | | $60 + 20% of charges | |
| 3 | 126-150% | Cost + $18.50 | $25 + 40% of charges | | | | | $60 + 40% of charges | |
| 4 | 151-175% | Cost + $19.50 | $25 + 60% of charges | | | | | $60 + 60% of charges | |
| 5 | 176-200% | Cost + $20.50 | $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:** | | | | | | | | | | | |
|  | | | | | | | | | | | |

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 2020 FPG published 1/13/2021 by the Federal Register for Health and Human Services https://aspe.hhs.gov/poverty-guidelines [↑](#footnote-ref-1)