# FULL CIRCLE HEALTH SLIDING FEE APPLICATION

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|---|---|
| **Responsible Party Name:** | |
| **Address:** | |
| **City, State, Zip Code:** | |
| **Telephone (circle one): Home/ Cell/ Work/ Other:** | |
| **Date of Birth:** | **Sex:** ☐ Male ☐ Female |
| **Social Security Number:** | |

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence. Your annual household income will be used to calculate the level of your payment.

| | |
|---|---|
| **Does anyone have Medicaid?** | ☐ Yes ☐ No |
| **Does anyone have Medicare?** | ☐ Yes ☐ No |
| **Does anyone have Veterans Assistance (VA)?** | ☐ Yes ☐ No |
| **Does anyone have Health Insurance?** | ☐ Yes ☐ No |
| **Would anyone like additional information on the health insurance exchange?** | ☐ Yes ☐ No |

**Family Size?** **Are you applying for pregnancy related assistance (OBO) program?** ☐ Yes ☐ No

**Are you applying for assistance for non-covered/excluded services from your health insurance plan?** ☐ Yes ☐ No

**Please list each family members current employer and fill out ALL fields related to that persons employment. If your family household has NO Income, please initial here. _____** (*Additional forms will need to be filled out.*)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Employer Name / Name of Person Employed | Start Date | Hours p/ week | Hourly or Salary Amount Paid | ☐ Hourly ☐ Salary | ☐ Weekly | ☐ Every 2 Weeks | ☐ Bi-Monthly | ☐ Monthly |
| 2 | Employer Name / Name of Person Employed | Start Date | Hours p/ week | Hourly or Salary Amount Paid | ☐ Hourly ☐ Salary | ☐ Weekly | ☐ Every 2 Weeks | ☐ Bi-Monthly | ☐ Monthly |
| 3 | Employer Name / Name of Person Employed | Start Date | Hours p/ week | Hourly or Salary Amount Paid | ☐ Hourly ☐ Salary | ☐ Weekly | ☐ Every 2 Weeks | ☐ Bi-Monthly | ☐ Monthly |

**Do you or anyone in your family household receive any income from any of the following sources, and if so, how much per month?**

| Sources | You | Your Spouse | Your Children | Other Person | Total Sources |
|---|---|---|---|---|---|
| Social Security/ Retirement Pension | $ | $ | $ | $ | $ |
| Unemployment/ Workers Compensation | $ | $ | $ | $ | $ |
| Income from Rental Property | $ | $ | $ | $ | $ |
| Child Support, Alimony | $ | $ | $ | $ | $ |
| Other (Specify) Ex: Interest Income | $ | $ | $ | $ | $ |

**Please list each family member who lives in your household. This includes parents and children, but not extended family members. Use a separate piece of paper if extra space is needed. Only one form is required per family.**

| | | |
|---|---|---|
| Name #1: | DOB: / / | Relationship: |
| Name #2: | DOB: / / | Relationship: |
| Name #3: | DOB: / / | Relationship: |
| Name #4: | DOB: / / | Relationship: |
| Name #5: | DOB: / / | Relationship: |
| Name #6: | DOB: / / | Relationship: |

1. I certify the information and identity provided here is true, complete, and accurate.
2. I give Full Circle Health permission to share my information with other organizations, grantors or providers (and their auditors) that provide discounted services to me at the request of Full Circle Health. Examples of such organizations are Patient Medication Assistance Program, referral networks, laboratories, medical imaging services, or medical specialists, etc.
3. I understand intentionally providing false information may exclude me from discounts at Full Circle Health. I may be billed for any discounts I received with false information. I understand that I must provide verification of income, financial assistance, dependents, bank statements, pay vouchers and tax statements if applicable.
4. I understand that if I am approved the Sliding Fee Program is in effect for 12 months from the date of approval. I will promptly notify Full Circle Health if my financial status changes (i.e. change in family size, change in employment, new employment, qualify for other assistance, etc.). If I need assistance after 12 months, I understand that I must re-apply for the Sliding Fee Program by submitting a new application with new supporting documents.

| | |
|---|---|
| **Responsible Party Signature:** | |
| **If Not Patient, Relationship to Patient:** | **Date:** |

**INSTRUCTIONS ON OTHER SIDE**

## Application Instructions

1. Only use **dark blue** or **black** ink when filling out the application.
2. Fill out the application completely and return all documentation within **10 days** to Full Circle Health.
3. This application can be dropped off at any of our clinic locations, e-mailed to: Registration@FullCircleIdaho.org, faxed to: **Fax #: 208-322-7018,** or mailed to the address below:
   **Full Circle Health**
   **Attn: Sliding Fee**
   **777 N Raymond St**
   **Boise, ID 83704**
4. **ALL FIELDS MUST BE COMPLETED.** Incomplete applications will not be processed until all information needed to process the application has been provided.
5. Discounts will be based on family/household income and family size. **Family is defined as:**
   a. Definition of family limited to spouse and/or dependents ("qualifying child" or "qualifying relative") per IRS definitions in Title 26, Section 151-152 of the tax code.
   b. Two unmarried persons living together who currently share minor children will be considered one household unit even if they do not file taxes together as they are sharing expenses.
6. If you have questions please contact our Financial Assistance Coordinator at **208-514-2515 ext. 3465**

***Copies of documents that must be attached to the application include:***

1. A copy of any and all income received for all family members (both adult and children) living at the same residence will need to be included and verified on the application. *See table below*
2. A personal statement as to why you are not working for any adults in the household.

| ✓ | **Income Type** | **Verification Needed** |
|---|---|---|
| | No Income | Sign the "Self-Declaration of Household Income," and a written note about where the patient is receiving help from |
| | Earnings from employment | Copy of most recent wage/pay stubs or letter from employer stating hourly/salary rate and hours per week expected to work. |
| | Earning from self-employed business | Profit/ loss statement for the last 3 months or most recent year's tax return |
| | Unemployment compensation | Unemployment benefits in the form of a eligibility determination or benefit payment summary (must be able to see benefit amount remaining or weeks remaining of benefit) |
| | Workers' compensation | Workers' compensation benefits in the form of a eligibility determination or benefit payment summary |
| | Social Security | Social security determination letter or bank statement from the last 30 days |
| | Supplemental Security Income | Bank statement or social security determination letter from the last 30 days |
| | Veterans' payments | Bank statement or Veterans' payments determination letter from the last 30 days |
| | Survivor benefits | Bank statement or survivor benefits determination letter from the last 30 days |
| | Pension or Retirement income | Bank statement or Pension or Retirement statement from the last 30 days |
| | Savings or Checking account funds | Bank statement for the last 90 days |
| | Rental Income from Property, Royalties, Trusts | Bank statement from the last 30 days |
| | Income from estates | Bank statement from the last 30 days |
| | Educational assistance (Financial Aid/Grants/Scholarships/Loans) | Bank statement showing direct deposit refund received from school or student loan/student grant information sheet. This sheet will show the total loan(s) and/or grant(s) received and the tuition expenses for the current semester/year |
| | Alimony | Bank statement from the last 30 days |
| | Child support | Child support history from Dept. of Health and Welfare for the last 5 payments even if no payment s have been received. |

**APPLICATION ON OTHER SIDE**