Sliding Fee Program Information

Thank you for selecting Infinity Health. Part of the mission for Infinity Health is to provide quality services to you and your family. In doing so, Infinity Health offers a sliding fee adjustment for patients and members of their family (as defined below) who fall below 200% of the poverty guidelines as set forth by the Federal Government. Income levels are based on total "family" income, family is defined below. The amount of the discount and the income ranges for those discounts are set by Infinity Health's Board of Directors and approved by the Federal Government. Income guidelines are revised annually. Current discounts and income guidelines are available at all Infinity Health sites.

The sliding fee application will cover all medically necessary medical, behavioral, and dental services. The costs of procedures, labs, tests, and provider visits that are deemed medically necessary will qualify for the sliding fee discount. The costs of procedures, labs, tests, and provider visits that are deemed optional, cosmetic, or experimental will be the responsibility of the patient requesting the services at 100% of the regular rate charged. Even if services are ordered by a provider, it does not necessarily mean that they are medically necessary.

DEFINITIONS

Family – A family means those persons within the same household (including their dependents / partner) who are applying for the sliding fee discount using their combined income. If an individual is claimed as a dependent on tax return, they should be in included in family size.

Examples:

- Two unrelated persons living in the same household, each paying their own rent, utilities, and expenses: Apply separately; list only your own income.
- Blended household, parents, children, and grandparents. **All adults contribute to pay expenses for the whole household, list all names and all incomes.**
- Adult child living with parents, child pays rent and all their own expenses. Apply separately for child/parents and each list only their own income.
- Adult child living with parents, adult child pays no bills. Joint application, list all incomes.

Individual – An individual is a person 18 years old or over who has verifiable income using the list below (*) and has no other guarantor other than self.

INCOME VERIFICATION

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify INFINITY HEALTH of that change. INFINITY HEALTH reserves the right to verify income with an employer at any time. **(*) Patients are required to provide at least one of the following items as verification of income.**

- **Previous year Federal tax return**
- **Current pay stubs (last 4 weeks, if possible)**
- **Lay-off notification from last employer**
- **Social Security Statements**
- **Current information from unemployment office**
- **Pay stubs from unemployment (last 4, if possible)**
- **Most recent W2**

Additional Income Information:

If you were not required to file the prior year's income tax return, or you receive any of the following types of income, documentation must be submitted showing the amounts of each received by any member of the household.

- **Child Support**
- **Welfare Assistance**
- **Social Security**
- **Unemployment**
- **Self-Employment Income**
- **Alimony**
- **Retirement Income**
- **Worker's Compensation**
- **Disability Income**
- **Scholarship/Grant Awards (for non-educational expenses)**
- **Any Other Income**

ELIGIBLE FEES

- Medical, Mental Health, Substance Abuse, Dental Services and Vision Exams that are provided at Infinity Health are eligible for the sliding fee discounts.
- **Previous charges, OWI assessments, elective procedures and outside services are NOT ELIGIBLE for a sliding fee discount.**
- **Deductibles exceeding $1,000.00 ARE eligible for sliding fee discounts.**

MINIMUM CHARGE

There is a minimum charge for all sliding fee visits as approved by the Infinity Health Board of Directors. The minimum charge **MUST** be paid at the time of service regardless of insurance coverage.

ADDITIONAL INFORMATION

- **Payment is required when services are rendered**.
- Timeliness in completing this application is important. Your application for the sliding fee discount **will not** be approved until **complete** documentation is received. If your slide is returned without income verification you will be notified by mail that income verification must be received within 30 days to finish the application.
- Until you are approved for a sliding fee discount, you will be responsible for the full charges associated with services you receive from Infinity Health unless any amounts are covered by other third-party sources. Once the application is complete, please return it to the office where you receive services. If you have any questions, staff at the office you receive services at will assist you.
- If approved for the Sliding Fee Program, your participation will begin 30 days prior to the date the application was returned to the Infinity Health office.
- All sections of application must be completed.

Thank you for choosing Infinity Health for your health care needs.

Sliding Fee Program Application

Patient's Name ______________________ Today's Date ______________

Home Address ______________________ City ______________

State __________ County __________ Zip Code __________ Sex: Female Male

Date of Birth ______________ Social Security No. ______________________

Home Telephone ______________ Work No. ______________ Emergency No. ______________

Marital Status of Patient: Single Married Separated Divorced Widowed

Employer / School ______________________ Occupation ______________

Employer's Address ____

Family Information

Number of people in your household (must be listed below) _____

Annual Gross Income (all adult members of household) $____________________

Insurance Information

Do you have any other insurance? Yes No If so, what kind__________________

Are you eligible for Medicaid? Yes No Have you applied? Yes No

Would you like more information, or help applying? Yes No

FOR OFFICE USE ONLY:

Source of Income verification:

Verification Date:

Verified By:

Accepted By:

Head of Household (or financially responsible party):

Name ______________________ Date of Birth ___________

Relationship to Patient ______________________ Social Security No. ______________________

Home Address ____

City ______________________ State ______________ Zip Code ______________

Home Telephone ______________________________

FAMILY SIZE: (*If additional space is needed, please add to back of page*)

Name	Date of Birth	Relationship	Annual Gross Income (adults only)

INCOME:

	Current Monthly	**Last 12 Months Total**
Wages or self-employment	$ __________________	$ __________________
Social Security / Public Assistance	$ __________________	$ __________________
Unemployment / Worker's Compensation	$ __________________	$ __________________
Alimony or Child Support	$ __________________	$ __________________
Pensions / Retirement Income	$ __________________	$ __________________
Welfare Assistance	$ __________________	$ __________________
Disability Income	$ __________________	$ __________________
Any Other Income	$ __________________	$ __________________

I declare under penalty of perjury, under the laws of the State of Iowa, that all statements contained in this application and accompanying documents is true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial of application.

I have read the Sliding Fee Application and I understand that payment is due at the time of service. If documentation of income verification is not given to INFINITY HEALTH within 30 days of this application, the application will no longer be valid, and I must reapply.

***Applicant*:**

SIGNATURE ____ DATE ________________________

Staff (when completed application turned into office):

SIGNATURE ____ DATE ________________________

For Office Use Only:

Qualifies for: ____________**%** Discount Ineligible

Date of Determination: ____________________ **Effective Date:** ____________ **Expiration Date:** ____________

Signature of person making eligibility determination: ____

Revised 12/27/2021