INFINITY HEALTH

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Sliding Fee Discount 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 discount program (SFDP) for patients and members of their family who are at or below 200% of the poverty guidelines as set forth by the Federal Government. Income levels are based on total "family" income, defined below. The amount of the discount and the income ranges for those discounts are set by Infinity Health's Board of Directors. Income guidelines are revised annually when Federal Poverty Guidelines (FPG) are updated. Current discounts and income guidelines are available at all Infinity Health sites.

The sliding fee discount program will apply to professional services rendered. Supplies will be discounted at cost plus markup and will be provided to the patient in advance of performing the service.

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.

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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 defines income as follows and requires supporting documentation as outlined below:

Income Type	Supporting documentation
Wages from employment	• Most recent 4 weeks of pay stubs OR • Most recent W-2 Form OR • Employer's statement of earnings
Self-employment income	• Business financial statements OR • Bank Statements
Child Support/Alimony	• Court statements OR • Deposit records/Bank Statements
Benefits from Social Security or other Government Programs	• Documentation of welfare assistance • Disability check stubs • Social security statements or check stubs
Pension/Retirement Income	• Pension check stubs OR • Annual benefit statement OR 1099-R
Worker's Compensation	• Award letter or agreement • Paystubs
*Adjusted Gross Income (AGI) from the Federal Tax return can be used to verify all of the above income types	• Pages 1 and 2 of the most recent year Federal Income Tax return (Form 1040)

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ELIGIBLE FEES

- Medical, Behavioral Health, Substance Use Counseling, and Dental Services that are provided at Infinity Health are eligible for the sliding fee discounts.

DISCOUNT STRUCTURE

- Slide B: patients with incomes at or below 100% of FPG - pay nominal fee.
- Slide C: patients between 101 and 125% of FPG pay 15% of total charges.
- Slide D: patients between 126 and 160% of FPG pay 40% of total charges.
- Slide E: patients between 161 and 200% of FPG pay 70% of total charges.
- Patients above 200% FPG do not receive a discount

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 any of our offices. If you have any questions, reception staff at any of our offices will be able 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.
- The amount collected for a minor patient's visit will be based on the minor patient's eligibility as per the application for which they are included for the SFDP regardless of who presents with the patient. **Example:** Minor child is brought in for a visit by someone other than the SFDP applicant.

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

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Sliding Fee Program Application

Patient's (Applicant's)Name _____ Today's Date _____

Home Address _____ City _____

State _____ County _____ Zip Code _____ Sex: Female Male

Date of Birth _____ Social Security No. (Optional) _____

Home Telephone _____ Work No. _____ Emergency No. _____

Marital Status of Patient (Optional): 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)**

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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: _____

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