INFINITY HEALTH

an iowahealth+ partner

Sliding Fee Discount Program Information

Applicant Full Name (First, MI, Last)	Date of Birth

Thank you for choosing Infinity Health!

Our mission is to provide high-quality care for you and your family. To help make our services accessible, we offer a **Sliding Fee Discount Program (SFDP)** for patients and their families whose income is at or below **200% of the Federal Poverty Guidelines**.

Eligibility is based on your total family income, as defined below. The discount amounts and income ranges are determined by Infinity Health's Board of Directors and updated annually when Federal Poverty Guidelines change. Current discount details and income guidelines are available at all Infinity Health locations.

The SFDP applies to **professional services**. Supplies will be provided at **cost plus markup** and shared with you before services are performed.

CHECK HERE ONLY IF YOU **DO NOT** WANT OT APPLY FOR THE SLIDING SCALE DISCOUNT

☐ I have been given the opportunity to apply for the Infinity Health services sliding fee discount program. I DO NOT wish to apply for a discount at this time.

Signature of Patient or Guarantor	Date

Interested in our Sliding Fee Discount Program?
If you'd like to apply, please complete the forms on the following pages.

The questions are designed to help us understand your family's needs so we can provide the best possible care—whether it's medical, dental, behavioral health, or pharmacy services.

- **If you're insured**, you may qualify for discounted copays or deductibles.
- **If you're uninsured**, you may qualify for reduced fees for services.

Your information will **never** be used to deny or withhold care. It's simply to ensure we can offer you the right level of support.

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)

ADDITIONAL INFORMATION

- 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.
- 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.

IMPORTANT:

- In order to receive the Sliding Fee Discount, you must return the completed application with income verification documents within 30 days of the application date. Self-declarations of income MUST be signed by all adults in the household. If we do not receive the documentation within 30 days, the application will be cancelled and no discount will apply.

For Office Use Only:

Eligibility: Annual income from verification documents **$**_____ Approved Slide level (circle) A B C D DNQ

Signature of person making eligibility determination: _____

Date_____

Sliding Fee Program Application

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

Home Address _____ City _____

State _____ County _____ Zip Code _____ Telephone _____

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

Marital Status of Applicant (Optional): Single Married Separated Divorced Widowed

Occupation _____

☐ Check here if unemployed ☐ Check here if retired

HOUSEHOLD INFORMATION

Please include yourself, your spouse/partner, and all dependents receiving 50% or more of their support from the head of household. If additional space is needed, please use the back of the page.

Name	**Date of Birth**	**Relationship to Applicant**	**Insurance**	**Insurance Type**
		Self	___ Yes ___ No	___Medicaid ___Medicare Other_____
			___ Yes ___ No	___Medicaid ___Medicare Other_____
			___ Yes ___ No	___Medicaid ___Medicare Other_____
			___ Yes ___ No	___Medicaid ___Medicare Other_____
			___ Yes ___ No	___Medicaid ___Medicare Other_____
			___ Yes ___ No	___Medicaid ___Medicare Other_____
			___ Yes ___ No	___Medicaid ___Medicare Other_____
			___ Yes ___ No	___Medicaid ___Medicare Other_____

INCOME VERIFICATION

Please enter your gross income (the dollar amount received before taxes are taken out) in the table below. Household income includes all income generated by everyone over 18 in the household. If zero income, please write "none"

Type of income	**Name of person receiving income #1** _____	**Name of person receiving income #2** _____	**Name of person receiving income #3** _____	**How often do you receive this income?**
Wages from Employment	$	$	$	___Weekly ___Bi-Weekly ___ Monthly ___Other:_____
Self Employment income	$	$	$	___Weekly ___Bi-Weekly ___ Monthly ___Other:_____
Child Support/Alimony	$	$	$	___Weekly ___Bi-Weekly ___ Monthly ___Other:_____
Social Security or other Government Programs	$	$	$	___Weekly ___Bi-Weekly ___ Monthly ___Other:_____
Pension/Retirement income	$	$	$	___Weekly ___Bi-Weekly ___ Monthly ___Other:_____
Workers compensation	$	$	$	___Weekly ___Bi-Weekly ___ Monthly ___Other:_____

- ☐ I will return copies of 1099s, W-2s or statements in support of the income listed above
- ☐ I will return a copy of my prior year completed tax return in lieu of individual statements for the income listed above
- ☐ I am **unable** to provide supporting documentation of the income listed above and wish to use this form as a self-declaration of income and I attest to the accuracy of the information above by signing below.

APPLICANT CERTIFICATION STATEMENT

I understand:

- 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.
- If I provide false information, I will be disqualified from the program and all charges will be due in full immediately.

By signing this form, I certify under penalty of perjury under the laws of the State of Iowa that the above information is true and correct, and I assume the responsibility of contacting Infinity Health, should any changes to my financial or insurance status occur.

Applicant Signature _____ Date _____

Adult income earner #2 (if self-attesting)_____ Date _____

Adult income earner #3 (if self-attesting)_____ Date _____