Application Instructions

1. Fill out the application completely and return all documentation within **10 days** to Family Medicine Health Center.
   This application can be dropped off at any of our clinics as well as mailed or faxed to: **Fax #: 208-322-7018**
   Family Medicine Health Center
   Financial Assistance Coordinator
   777 N Raymond St
   Boise, ID 83704
2. Incomplete applications will not be processed until all information needed to process the application has been provided.
3. Discounts will be based on family/household income and family size. **Family is defined as:**
   a. **A group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.**
4. If you have questions please contact our Financial Assistance Coordinator at **208-514-2500 ext. 1115**

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

1. A copy of a valid identification card or driver's license.
2. If applying for pregnancy related assistance (OBO), applicants must provide address verification such as a utility or phone bill.
3. A copy of any and all income received for all household members (both adult and children) will need to be disclosed and verified on the application. *See table below*
4. A personal statement as to why you are not working for any adults in that are not working.

✓	Income Type	Verification Needed
	No Income	Sign the "Self-Declaration of Household Income," and have person supporting you fill out the "Supplemental Contribution Statement."
	Earnings from employment	Copy of 30 days most recent wage/pay stubs or letter from employer stating hourly/salary rate and hours per week expected to work for all adult household members.
	Earning from self-employed business	Profit and loss statement for the last 3 months
	Unemployment compensation	Unemployment benefits in the form of a eligibility determination or benefit payment summary
	Workers' compensation	Workers' compensation benefits in the form of a eligibility determination or benefit payment summary
	Social Security	Bank statement or social security determination letter from the last 30 days
	Supplemental Security Income	Bank statement or social security determination letter from the last 30 days
	Public assistance	Bank statement or letter of determination 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
	Interest and/or Dividends	Bank statement or Interest statement from the last 30 days
	Rents, 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 refund received or student loan/student grant information sheet. This sheet will show the total loan(s)/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
	Assistance from outside the household or miscellaneous sources.	Have whoever is providing you assistance fill out the "Supplemental Contribution Statement."
	Noncash benefits (food stamps and housing subsidies) do not count	No verification needed

FAMILY MEDICINE HEALTH CENTER

Sliding Fee Application

- ❑ Answer each question and **return this form within 10 days**.
- ❑ Attach a copy of two or more wage stubs for any and all employment within the **past 30 days** for all adults in the household.
- ❑ If you are self-employed attach a **current** profit and loss statement for the last 3 months.
- ❑ If you have no income**,** attach an "earnings projection" from the Department of Labor along with a letter explaining/documenting how your living expenses are paid for.
- ❑ Attach a copy of a valid identification card or driver's license.

Please fill out with dark blue or black ink. If a field and/or section does not apply to you, it must be filled out with "N/A." All questions and sections must be filled out.

If we need additional information, you will be notified by telephone or U.S. Mail as we cannot complete your application for FMRI financial assistance if we do not have all of the information required.

Patient Name: ________________________________ **Date of Birth:** ______________________________
Address: ___________________________________ **Telephone:** ________________________________
City ____________________ **Zip** _______________ **Social Security Number:** XXX-XX-______________

Living Status: ❑ Own ❑ Rent ❑ Homeless shelter ❑ Transitional ❑ Doubling up ❑ Street ❑ Unknown
❑ Other: _______________________

Race: (choose one)
❑ Asian ❑ American Indian/ Alaska Native ❑ Black/ African American ❑ Native Hawaiian/ Other Pacific Islander ❑ White/ Caucasian ❑ Hispanic/ Latino ❑ Unknown ❑ More than one race

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Agricultural Work Status: ❑ Non-Agricultural ❑ Seasonal ❑ Migrant ❑ Employed Year Round ❑ Retired Farm Worker

Veteran Status:
❑ Veteran ❑ Non-Veteran

Are you applying for pregnancy related assistance (OBO) program?
❑ Yes ❑ No

Additional household members: (provide the following information and attach additional sheet if necessary)

Name	Date of Birth	Relationship to Patient	Social Security Number
			XXX-XX-
			XXX-XX-
			XXX-XX-
			XXX-XX-
			XXX-XX-
			XXX-XX-

Insurance Information:
Do you have Health Insurance? ❑Yes ❑No
Do you have Medicaid? ❑Yes ❑No......... If "No", have your applied? ❑Yes ❑No
Do you have Medicare? ❑Yes ❑No
Do you have Veteran's Assistance? ❑Yes ❑No
Do you have Student Health Insurance? ❑Yes ❑No

HOUSEHOLD INCOME FROM EMPLOYERS

Person(s) Employed	Employer	Hourly Wage	Hours per Week	Monthly Total	Start Date	End Date
		$				
		$				
		$				
		$				
		$				
		$				

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FAMILY MEDICINE HEALTH CENTER

HOUSEHOLD INCOME FROM OTHER SOURCES (taxed or not)

Child Support / Alimony Received	$
Food Stamps / Foster Care / Housing Assistance / Other Public Assistance	$
Pension / Social Security/Social Security Disability / Retirement Income / Survivors Benefits	$
Rental Property / Royalty Income / Income from Estates and Trusts	$
Stocks / Bonds / Annuities / Interest / Dividends	$
Unemployment / Worker's Compensation	$
Other Income (assistance from family / friends, or odd jobs)	$
TOTAL MONTHLY INCOME	$

*****Other information we should know? If the household expenses exceed monthly income, please describe how monthly obligations are met.**

Please initial in boxes:

- ☐ **I certify that all information is true and complete to the best of my knowledge. Any false information will result in my termination from this program regardless of when the information is discovered.**
- ☐ **I understand that the information provided will be verified and treated as confidential except when utilized to apply for other programs or financial assistance such as the Patient Medication Assistance program, FMHC Pharmacy or Volunteer Physician Network.**
- ☐ **I authorize Family Medicine Health Center to obtain a credit report, as deemed necessary, and to verify banking information / employment information.**
- ☐ **I understand that I must provide verification of income, financial assistance, dependents, bank statements, pay vouchers and tax statements if applicable.**
- ☐ **I also understand that I will be liable for full payment of any services rendered at the Family Medicine Health Center if the above information is given under false pretenses.**
- ☐ **I understand that I am responsible to notify Family Medicine Health Center if my financial status changes (i.e. change in employment, new employment, qualify for other assistance, etc.).**
- ☐ **I know that I am asking for financial assistance from Family Medicine Health Center only and not from other health care providers or physicians.**

Signature: ______________________ **Date:** ______________

777 N Raymond | Boise, ID 83704 | tel 208.514.2500 | fax 208.375.2217 | www.myfmhc.org