NOTICE OF AVAILABILITY OF SLIDING FEE DISCOUNT PROGRAM

Benefis Teton Medical Center Community Clinic will provide Sliding Fee Discounts to persons who are unable to pay for medical services and who meet the following guidelines. Eligibility for Sliding Fee Discounts will be limited to clinic accounts whose family gross income is at or below 100% of the poverty guidelines. An account in bad dept collections will not be considered for Sliding Fee Discount eligibility without administrative approval. A nominal payment of $10 is desired per visit. Those meeting policy guidelines will be considered for reduced cost in accordance with the schedule below.

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Proverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
	CHARGE					
Family Size	Nominal Fee ($10)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0-$11,880	$11,881-$14,850	$14,851-$17,820	$17,821-$20,790	$20,791-$23,760	$23,761+
2	0-$16,020	$16,021-$20,025	$20,026-$24,030	$24,031-$28,035	$28,036-$32,040	$32,041+
3	0-$20,160	$20,161-$25,200	$25,201-$30,240	$30,241-$35,280	$35,281-$40,320	$40,321+
4	0-$24,300	$24,301-$30,375	$30,376-$36,450	$36,451-$42,525	$42,526-$48,600	$48,601+
5	0-$28,440	$28,441-$35,500	$35,501-$42,660	$42,661-$49,770	$49,771-$56,880	$56,881+
6	0-$32,580	$32,581-$40,625	$40,626-$48,870	$48,871-$57,015	$57,016-$65,160	$65,161+
7	0-$36,730	$36,731-$45,913	$45,914-$55,095	$55,096-$64,278	$64,279-$73,460	$73,461+
8	0-$40,890	$40,891-$51,113	$51,114-$61,335	$61,336-$71,558	$71,559-$81,780	$81,781+
For each additional person, add	$4160	$5,200	$6,240	$7,280	$8,320	$8,320

- Based on 2016 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)

- A W2, two most recent pay stubms, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business.
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BENEFIS TETON MEDICAL CENTER COMMUNITY CLINIC SLIDING FEE DISCOUNT FOR ELIGIBILITY DETERINATION

PATIENT'S NAME_____ SSN #_____
LAST FIRST MI

ADDRESS_____ PHONE #_____
MAILING ADDRESS CITY STATE/ZIP

NUMBER OF PERSONS IN FAMILY_____

NAME OF DEPENDENTS RESPONSIBLE FOR (AS CLAIMED ON INCOME TAX RETURNS)

NAME	RELATIONSHIP	AGE	NAME	RELATIONSHIP	AGE

EMPLOYER_____ ADDRESS_____

LENGTH OF EMPLOYMENT_____ POSITION_____

SALARY: BEFORE DEDUCTIONS $_____ BASIS OF PAY: HOURLY_____ DAILY_____
WEEKLY_____ MTHLY_____

SPOUSES EMPLOYER_____ ADDRESS_____

LENGTH OF EMPLOYMENT_____ POSITION_____

SALARY: BEFORE DEDUCTIONS $_____ BASIS OF PAY: HOURLY_____ DAILY_____
WEEKLY_____ MTHLY_____

OTHER SOURCES OF INCOME

SOCIAL SECURITY $_____ OTHER PERSONS $_____ WELFARE $_____
CHILD SUPPORT $_____ RAILROAD RETIREMENT $_____VETERANS PENSION $_____
WORKERS COMPENSATION $_____ UNEMPLOYMENT $_____ OTHER $_____

FAMILY INCOME LAST TWELVE (12) MONTHS: $_____

COMMENTS_____

BENEFIS TETON MEDICAL CENTER COMMUNITY CLINIC
SLIDING FEE DISCOUNT SERVICES STATEMENT

PATIENT NAME_____ DATE_____

For services already rendered by Benefis Teton Medical Center Community Clinic, list date of services and dollar amount:_____

_____

For services not rendered, list expected date of services and dollar amount:

_____ _____

I hereby request from Benefis Teton Medical Center Community Clinic that financial assistance be provided to me, or my family member named above, as may be determined by Benefis Teton Medical Center Community Clinic's policy. In requesting these Sliding Fee Discounts, I certify that the foregoing information is true, accurate and complete. I also certify that at this time I am unable to pay for the health services in full. I understand that the information, which I submit, may be subject to review by Federal and/or State enforcement agencies and others as required by law. In order that Benefis Teton Medical Center Community Clinic may act upon my request for Sliding Fee Discounts, I hereby agree to supply the Clinic, its managers, operators, agents or employees, such additional information as the Clinic may reasonably require in order to substantiate my income. I do hereby further release Benefis Teton Medical Center Community Clinic, and their respective agents and employees, from all liability out of their reasonable efforts to verify the information I have stated in this request.

_____ _____

Requester Signature
(Requested on behalf of patient)

Patient Signature

_____

Relationship to Patient

To be completed by Benefis Teton Medical Center

Accepted _____

Authorized Signature Date

Declined _____

Authorized Signature Date

10/25/13 updated 9/18/16 updated 12/15/16