



## Introduction to the Sliding Fee Discount Program Application

It is the policy at Cascade Medical Center to provide essential services to all patients regardless of their ability to pay. Cascade Medical Center offers a Sliding Fee Discount Program (SFS) for any patient that is unable to pay for their services. The SFS program uses the current year's Federal Poverty Levels to determine eligibility. Cascade Medical Center does not discriminate based on age, gender, race, sexual orientation, creed, religion, disability, or national origin.

If approved, the SFS discount will apply to any service performed at Cascade Medical Center (i.e., visits, x-rays, labs) but not those services provided by external providers, such as prescriptions, durable medical equipment, reference laboratory testing or services referred outside of Cascade Medical Center for specialist care.

Photo Identification must be provided when applying for the sliding fee program. This can be either a State Issued Driver's License, State Issued Standard ID, Passport or Military ID for all adults in the household.

Proof of income verification is required in order to participate in the SFS program. Applicants must provide one of the following:

- Prior Years' W-2 Form or:
- Three most recent paystubs or:
- Income Verification Letter from employer or:
- A copy of your most recent federal tax returns for each individual living in the household in unable to provide the prior three options.

If the applicant has had no income in the past three months or more; this must be verified through some other official agency record. Acceptable examples would be:

- Copy of the last filed Federal tax returns or:
- Last 3 months of Bank Statements or:
- Written statement from a Landlord, Faith or Spiritual Leader, or Self-declaration.

Self-employed individuals will be required to submit details of the most recent three months of income and expenses for the business. This can be:

- Bank Statements for both Personal and Business Accounts
- Income Statement, P&L Statement or Balance Sheet

If you feel you qualify for the sliding fee program, please complete the attached application form and return it to Cascade Medical Center. **You must return the completed application and submit verification data within ten (10) business days from your date of service to apply the sliding fee discount to that visit.** You will be notified in writing when your application has been processed regarding your eligibility.

If approved, your application will have a **valid term of six-months (6)** unless there is a substantial change in household makeup or income. Applicants eligibility will be reviewed whenever any changes are reported. It is your responsibility to reapply when the current eligibility period is nearing or has expired.

**SLIDING FEE DISCOUNTS (SFD) APPLY ONLY TO ORDERS OR SERVICES, WRITTEN AND RENDERED, BY CASCADE MEDICAL CENTER & CASCADE FAMILY PRACTICE PROVIDERS.**

**For any questions, please contact Patient Financial Services at Cascade Medical Center, (208) 408-5027.**



**Financial Assistance Program Application**  
**You may qualify for Sliding Fee Discount even if you have insurance.**

Date of Request: \_\_\_ / \_\_\_ / \_\_\_ (Return Completed Application in Ten Business Days or Before Appt.)

Patient's Name: (print) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number (or message number): \_\_\_\_\_

Number of Persons Residing in Household: \_\_\_\_\_

Name of all residents in household	Date of Birth	Relationship	SSN (Optional)	Employer	Applying for Discount	
					Yes	No
		Self				
		Spouse/Partner				
		Child/Dependent				
		Child/Dependent				
		Child/Dependent				

If more room is needed for Children or Dependents please add them to the back of the form.

**Income/Note: YOU MUST PROVIDE INCOME VERIFICATION.**

Annual Household Income				
Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, disability, pension, annuity, veteran's benefits				
Alimony, child support, military family allotments, AFDC				
Unemployment, workers compensation, strike benefits, etc.				
Rent income, interest, dividends, and other income				
<b>Total income for the last twelve (12) months</b>				

Do you have any insurance coverage for:

**Medical charge(s):** Yes \_\_\_ No \_\_\_

If yes: Medicaid \_\_\_ Medicare \_\_\_ Private Insurance (Name) \_\_\_\_\_

Verification Checklist (attach copies)	Yes	No
Identification: Drivers license, Govt Photo ID, Passport or Military ID for EACH adult on application		
Income: Tax returns, pay stubs, or other		

**I certify that the information shown above is correct and understand verification is required for approval.**

\_\_\_\_\_  
**Applicant Name (Print)**

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

**For Office Use Only**

Date Application Received: \_\_\_\_\_

Received by: \_\_\_\_\_

Discount % Pay Class: Primary: \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Name \_\_\_\_\_

Valid \_\_\_\_\_ to \_\_\_\_\_ Approved by: \_\_\_\_\_