SLIDING FEE SCALE APPLICATION

Many Terry Reilly patients qualify for a DISCOUNT on their health care, even if they have insurance. Please complete this form if you would like to apply for our sliding fee scale. Medication Assistance Program through the Terry Reilly pharmacy is a separate application and income verification process.

You must reapply for a sliding fee discount annually or when there is a change in income, insurance or family size.			
Responsible Party (Head of Household) Information:			
Name:			DOB:
Phone: ( )	Social Security #:		Sex: ☐ Male ☐ Female
Address :	City:	State:	Zip:

Please list each family member who lives in your household. This includes parents and children, but not extended family members. Use the back of the form if extra space is needed. Only one form is required per family.		
There are _____members in my household		
Name #1:	DOB: / /	Relationship:
Name #2:	DOB: / /	Relationship:
Name #3:	DOB: / /	Relationship:
Name #4:	DOB: / /	Relationship:
Name #5:	DOB: / /	Relationship:

Gross annual income **before taxes** must include all sources of income (wages, Social Security, unemployment, income from assets, pension, child support). If you have NO Income, please initial here._____

Income source #1	$_____ paid → ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly	_____ Hours per week
Income source #2	$_____ paid → ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly	_____ Hours per week
Income source #3	$_____ paid → ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly	_____ Hours per week
Income source #4	$_____ paid → ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly	_____ Hours per week
Income source #5	$_____ paid → ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly	_____ Hours per week

Total income from all sources $_____

- I certify the information provided here is true, complete and accurate. I will promptly notify Terry Reilly of changes in insurance, family income or size.
- I give Terry Reilly permission to share my information with other organizations, grantors or providers (and their auditors) that provide discounted services to me at the request of Terry Reilly. Examples of such organizations are laboratories, medical imaging services, or medical specialists, etc.
- I understand intentionally providing false information may exclude me from discounts at Terry Reilly. I may be billed for any discounts I received with false information. I understand my verification of income may be audited for accuracy and I agree to provide all records as requested.
- Terry Reilly Health Services may access my information from the Idaho Department of Health and Welfare's Partner Data Access Portal (PDAP) to determine my eligibility for discounts on healthcare.

Responsible Party Signature: _____

If Not Patient, Relationship to Patient: _____ Date: _____

Based on this form, you are approved for Plan _____ discount on qualified services. Staff initials: _____ Date: _____