Terry Reilly Health Services

Sliding Fee Application INSTRUCTIONS

1. All fields must be completed.
2. If a field does not apply, mark N/A.
3. Application is not considered complete until all forms of verified income are received.
4. Completed application and income verification forms can be submitted to front desk.

To submit by mail: Terry Reilly Health Services, 211 16th Ave. North, Nampa ID 83653 (income verifications forms should be copies. Original documents will not be returned)

Advisory: Your application will become void if income verification is not supplied within 30 days of signing. **Patient will be charged full fees until an application is completed and submitted.**

If you are employed:	• Paystubs issued from all employers within the last 30 days • or a bank statement with 30 days of history • or a tax return filed within last 90 days
If you are self-employed:	• Tax return filed within the last 90 days • or a current bank statement showing 90 days of income • A profit & loss statement for the previous 12 months
If you are paid in cash:	• A bank statement with 90 days of history • AND a signed and dated letter from your employer listing: - Your name - Employer's name - Initial date of employment - Rate of pay and frequency
If you collect unemployment or workman's compensation:	• Bank statement with 30 days of history • or official notification stating amount of benefit and weeks remaining.
Do you receive other assistance? Check all that apply _____Worker's Compensation _____Social Security _____Supplemental Income (SSI) _____Pension/retirement _____Rental property income _____Trust or estate funds _____Child Support _____Alimony _____Veteran's benefit _____Survivor's benefit	• Bank statements with 30 days of history • or current determination letter/benefit summary.
If you have no household income:	Further verification is required.

Responsible Party:	
Address:	Apt #:
City, State, Zip Code:	
Telephone:	☐ Home ☐ Work ☐ Cell ☐ Other
Date of Birth:	Sex: ☐ Male ☐ Female
Social Security Number or TIN:	

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Family Size:

Family or household size is the number of immediate family members, including the applicant, who are at least 50% dependent on the income reported on this application.

List household members; parents, children, but not extended family members.

			Check here if also a Terry Reilly patient
Name #1:	Date of Birth:	Relationship:	
Name #2:	Date of Birth:	Relationship:	
Name #3:	Date of Birth:	Relationship:	
Name #4:	Date of Birth:	Relationship:	
Name #5:	Date of Birth:	Relationship:	

Please complete all employment information for each family member.

	Name of Person Employed / Employer Name	Start Date	Hours p/ week	Hourly or Salary Amount Paid	
	Name of Person Employed / Employer Name	Start Date	Hours p/ week	Hourly or Salary Amount Paid	☐ Hourly ☐ Weekly ☐ Bi-Monthly ☐ Monthly ☐ Salary
	Name of Person Employed / Employer Name	Start Date	Hours p/ week	Hourly or Salary Amount Paid	☐ Hourly ☐ Weekly ☐ Bi-Monthly ☐ Monthly ☐ Salary
	Name of Person Employed / Employer Name	Start Date	Hours p/ week	Hourly or Salary Amount Paid	☐ Hourly ☐ Weekly ☐ Bi-Monthly ☐ Monthly ☐ Salary

Please list all sources of family income. If your family household has no income, please initial here: _____
Further verification will be required.

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security/ Retirement Pension	$	$	$	$	$
Unemployment/ Workers Compensations	$	$	$	$	$
Income from Rental Property	$	$	$	$	$
Child Support, Alimony	$	$	$	$	$
Other (Specify) Ex: Interest Income	$	$	$	$	$

- ☐ I have provided true and complete information which I authorize Terry Reilly to verify.
- ☐ Terry Reilly Health Services has permission to share my financial information with healthcare entities that may provide discounted services. Examples: medication assistance program, referral networks, laboratories, imaging services, or specialists.
- ☐ I understand that providing false information may exclude me from discounts at Terry Reilly and I may be billed for any discounts I receive using false information.
- ☐ I understand sliding fee discounts are in effect for 12 months from date of approval. If assistance is needed after that time, I must re-apply.
- ☐ I will notify Terry Reilly within 10 days if my financial status changes. Examples: change in family size, employment status, new job, qualify for other assistance, etc.
- ☐ I understand my application will be denied if income documentation is not provided within 30 days of signing this application and that if denied, I will need to restart the application process.

By signing I agree to all the above statements

Responsible Party Signature:	**Date:**
Relationship to Patient:	