

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:	<ul style="list-style-type: none"> • Paystubs issued from all employers within the last 30 days • or a tax return filed within last 90 days
If you are self-employed:	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • A bank statement with 90 days of history • AND a signed and dated letter from your employer listing: <ul style="list-style-type: none"> - Your name - Employer's name - Initial date of employment - Rate of pay and frequency
If you collect unemployment or workman's compensation:	<ul style="list-style-type: none"> • Bank statement with 30 days of history • or official notification stating amount of benefit and weeks remaining.
<p>Do you receive other assistance?</p> <p>Check all that apply</p> <p><input type="checkbox"/> Worker's Compensation</p> <p><input type="checkbox"/> Social Security</p> <p><input type="checkbox"/> Supplemental Income (SSI)</p> <p><input type="checkbox"/> Pension/retirement</p> <p><input type="checkbox"/> Rental property income</p> <p><input type="checkbox"/> Trust or estate funds</p> <p><input type="checkbox"/> Child Support</p> <p><input type="checkbox"/> Alimony</p> <p><input type="checkbox"/> Veteran's benefit</p> <p><input type="checkbox"/> Survivor's benefit</p>	<ul style="list-style-type: none"> • 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:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Other
Date of Birth:	
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.

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:

If your family household has no income, please initial here:
Further verification will be required.

Please complete all employment information for each family member.

Name of Person Employed	Start Date	Hours p/week	Hourly or Salary Amount Paid	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Salary				
	Employer Name							
Name of Person Employed	Start Date	Hours p/week	Hourly or Salary Amount Paid	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Salary				
	Employer Name							
Name of Person Employed	Start Date	Hours p/week	Hourly or Salary Amount Paid	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Salary				
	Employer Name							

Please list all sources of family income.

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:	

Reviewed by (full name): _____