103 E. Main Street, P.O. Box 10, Fruitland, MD 21826
Phone: (410) 831-3899 ~ FAX: (443) 210-2786
laura@ihs-delmarva.com

PLEASE RETURN APPLICATION IMMEDIATELY TO ENSURE ACCURATE PROCESSING OF YOUR ACCOUNT

APPLICATION FOR SLIDING SCALE FEE

FOR OFFICE USE ONLY

_____ **Approved** _____
(Initial)

_____ **Not Eligible at time of service** _____
(Initial)

PLEASE PRINT

Date: _____/_____/_____ Patient's Social Security #: _____

Patient's Name: _____

Patient's Date of Birth: _____ /_____ /_____

Patient's Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Are you a Maryland resident? ☐ Yes ☐ No

Eligibility for Inspiration Health Services sliding fee scale financial assistance is based on income levels relative to the Federal Poverty Guidelines (FPG) published annually & the number of individuals living in your household. Certain sources of income are excluded from the calculation of household income (see below)

Please list the following **MEMBERS** of your household *(self, spouse, significant other, and children, including stepchildren and legally adopted children, up to 18 years of age)*. List **ALL** income earned by the listed members.

(Proof of income for all listed must be returned within 7 days or next scheduled appointment, whichever comes first)

Name	Relationship	Date of Birth	Social Security # (If applicable)	Yearly Income
	SELF			

Comments: _____

_____

If no members of your household earn income used to calculate eligibility for the sliding scale fee, please check the box below and the appropriate box within the means of support.

☐ I attest that all members of my household have **NO INCOME**.

Please note that all applications must be updated annually.

MUST SUBMIT **TWO** FORMS OF DOCUMENTATION OF INCOME STATED BELOW FOR EACH HOUSEHOLD MEMBER IN ORDER TO DETERMINE ELIGIBILITY.

Documents Accepted as Proof of Income (POI):

- ☐ Pay Stubs *(2 pay stubs if Bi-Weekly or 4 if weekly)*
- ☐ W2 Tax Form
- ☐ Tax Return Form #1040 (Line 7b) **(Total Income)**
- ☐ Tax Return Form #1040SR (Line 7b) **(Total Income)**
- ☐ Social Security (Staff: Read contents of letter)
- ☐ Unemployment (for 6 months)
- ☐ Letter from Employer

If you attest to No Income, please check means of support:

- ☐ Disability
- ☐ Child Support
- ☐ Temporary Cash Assistance
- ☐ SSI (Supplemental Security Income)
- ☐ Social Security Disability
- ☐ Other _____

Please answer the following survey questions:

Inspiration Health Services nominal fee for medical and behavioral health service is $25. Do you feel this charge is **(check one):** ☐ **Fair/Adequate** ☐ **Too Expensive** ☐ **Would prevent me from seeking care**

If you checked "Too expensive or Would prevent me from seeking care" please provide your opinion of an appropriate fee: $_____

I certify under penalties of perjury, that the statements above are true, accurate and complete to the best of my knowledge and belief.

_____ _____

Applicant/Guarantor's Signature Date

FOR OFFICE USE ONLY

Monthly: _____ _____ X **12** = _____
in Household | Gross | 12 mo. | Total Amount

Weekly: _____ _____ X **52** = _____
in Household | Gross | 52 weeks | Total Amount

Bi-Weekly: _____ _____ X **26** = _____
in Household | Gross | 26 weeks | Total Amount

Qualifying Level: ☐ Nominal ☐ Level I ☐ Level II ☐ Level III

Billing Representative Printed Name: _____

Billing Representative Signature: _____ Date: _____

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STATEMENT OF PATIENT FINACIAL RESPONSIBILITY

Thank you for choosing Inspiration Health Services (IHS) for your healthcare needs. We are honored by your choice, and we are committed to providing you with the highest quality of healthcare. We ask that you read the following information to understand our policy regarding self-pay patients and the sliding fee scale discount that we offer, as follows:

Please be aware that IHS expects the information you provided to apply for the sliding scale fee discount to be true, complete, and accurate. The information that you are providing concerning the size of your family (i.e., as family composition would be reported on an IRS tax return) and your family's gross annual income, from all sources (e.g., earned income, Social Security benefits, SSI, unemployment benefits, etc.), must be correct to the best of your knowledge. IHS may request additional information, if needed, to determine eligibility. **You are also responsible for promptly notifying IHS of changes of insurance, family income or size.**

IHS relies on information concerning your financial situation and your means and ability to pay in order to determine the applicable discount for services rendered to you.

Therefore, if IHS has reason to suspect that the information you have given is untrue, incomplete, or inaccurate or that you have not properly reported changes, IHS may initiate a review of your financial status. If you are found to have provided untrue information, you may be billed for any discounts you have received and possibly forfeit eligibility for the sliding fee program.

Sign below once you have read the agreement

_____ _____

Applicant Printed Name Date

_____ _____

Applicant Signature Date

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INFORMED CONSENT FOR REDUCED LAB FEES

PLEASE PRINT

Patient's Name: _____ D.O.B. _____/_____/_____

I hereby give consent to have lab work performed by Inspiration Health Services (IHS). I understand I will receive reduced lab fees, provided I pay the day the service is performed. If payment is **NOT** received the day of service, I understand I will be billed and responsible for the LabCorp fees at a much higher rate. If I have insurance coverage, a deductible may have not been met. If additional confirmation, reflex and/or "add on" testing is deemed necessary by LabCorp and/or my provider, I understand my account will be charged for this/these test(s) at the discounted rate.

_____	_____	_____
Patient or Legal Guardian – please print	Patient Signature or Legal Guardian	Date

_____	_____	_____
IHS Witness - please print	IHS Witness Signature	Date