Idaho State UNIVERSITY

ISU Family Dentistry
1311 E. Central Dr., Meridian, ID 83642
Phone: 208.373.1855 / Fax: 208.373.1856

Sliding Fee Scale

A sliding fee discount is an adjustment to customary charges for patients who meet certain criteria. The fee reduction is based on income and family size of the patient's household. Eligibility for the discount is offered to individuals who are at or below 200 percent of the current Federal Poverty Guidelines which is updated annually.

Account Name: _____ **SS No.:** _____
Address: _____
_____

Referred By: ☐ Agency ☐ Dentist ☐ Friend ☐ Other: _____

Household Information (Including yourself, list all of the people who live in your home and are dependents on your most recent tax return.)

Name (first, middle, last)	Relationship	Date of Birth

Household Income

Income Description	Monthly Income	Annual Income	Verification Information
Wages and Tips			
Aid to Families w/Dependent Children			
Food Stamps			
Child Support / Alimony			
Unemployment Benefits			
Social Security Benefits			
Retirement / Pensions			
VA Benefits			
Farm or Self Employment			
Other			
TOTAL INCOME			

Note: Income verification must be received and reviewed for approval and is completed annually or more frequently if circumstances change. Income/benefits information is confidential and is used for purposes of Sliding Fee Scale only.

Documentation needed for verification includes the following documents: copy of most recent tax return; all W2's; Social Security, Child Support, Unemployment, VA or Retirement Receipts. Please contact our Dental Receptionist Coordinator at 208-373-1855 for assistance if you are unsure about documentation requirements.

I authorize ISU Family Dentistry to verify the income sources through contact with employers, state and/or federal agencies. I understand that knowingly providing false information may result in criminal, civil or administrative action (including repayment of benefits).

I swear that the information on this form is true and correct.

Guarantor Signature: _____ Date: _____

Approved By: _____ Date: _____