Our Dietary Sliding Fee Discount Program is available to all patients who qualify based on their annual household income and family size even if they have insurance. Fees, copays, co-insurance, and deductibles are eligible for a sliding fee discount. The table below will help determine if you qualify.

Payment Obligation

	Slide A	Slide B	Slide C	Slide D	Slide E	Slide F
Family Size	A 0-100% FPG	101-125% FPG	126-150% FPG	151-175% FPG	176-200% FPG	Over 200% FPG
	Patient pays $20	Patient pays $25	Patient pays $30	Patient pays $35	Patient pays $40	Usual 30% charges discount for payment in full
1	$0 - $13,590	$13,591- $16,988	$16,989 - $20,385	$20,386 - $23,783	$23,784 - $27,180	$27,181 +
2	0 – $18,310	$18,311 - $22,888	$22,889 - $27,465	$27,466 - $32,043	$32,044 - $36,620	$36,621+
3	0 - $23,030	$23,031 - $28,788	$28,789 - $34,545	$34,546 - $40,303	$40,304 - $46,060	$46,0641+
4	0 - $27,750	$27,751 - $34,688	$34,689 - $41,625	$41,626 - $48,563	$48,564 - $55,500	$55,501+
5	$0 - $32,470	$32,471 - $40,588	$40,589 - $48,705	$48,706 - $56,823	$56,824 - $64,940	$64,941+
6	0 - $37,190	$37,191 - $46,488	$46,489 - $55,785	$55,786 - $65,083	$65,084 - $74,380	$74,381+
7+	$0 - $41,910	$41,911 - $52,388	$52,389 - $62,865	$62,866 - $73,343	$73,344 - $83,820	$93,261+

The 2022 Poverty Guidelines for the State of Idaho

Family Size	Income
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120
9	$48,600
10	$53,080

Sliding Fee Discount Program Application

It is the policy of Idaho Falls Community Hospital to provide services regardless of the patient's ability to pay. Idaho Falls Community Hospital offers a Sliding Fee Discount Program designed to allow patients to pay for healthcare services based on family size and income. The discount will apply to services received at Mountain View Hospital and its affiliate clinics. Some exclusions apply.

To apply for the Sliding Fee Discount Program, please complete the following information and return to The Dietitian prior to services, with proof of household income and photo identification. Applications can be brought into the hospital physically or emailed to krstickley@ifcommunityhospital.com
To remain eligible for the discount, recertification is required every six months or if your family/ financial situation changes.

Applicant Name: ____

Current Address: ____

____

Email Address: ____

Phone Number: __________________ Alternate Phone Number: ________________

Please list all household members			Date of Birth	Relationship to
First	MI	Last	MM/DD/YYYY	Patient

I, ____________________________ (print name), certify that the information provided is correct to the best of my knowledge. I agree to notify Mountain View Hospital if there are any changes in my household size or income. I am aware that this information is reviewed based on the Federal Poverty Guidelines published annually by the Federal Government. **I understand that I must recertify every six months.**

X____

Signature of Applicant or Responsible Party Date