Billing Ph #: 970-335-2342
FAX #: 970-335-2439

AXISHealth System

SLIDING FEE APPLICATION
2350.153

Application Date		**MUST BE LEGIBLE**	
Updated Application (New Information)	□ Yes □ No	Last Application Date (if applicable)	

In evaluating a patient eligibility for the Sliding Fee Discount Program in compliance with Federal regulations, **it is necessary to ask personal questions about the patient and their family/household.** The answers provided by the patient and their family/household will be kept on file and in strict confidence. The patient's eligibility is **based solely on the basis of the patient's ability to pay (i.e. income) and family/household size** and does not discriminate on the basis of age, gender, race, creed, sexual orientation, disability, national origin or legal status.

This application is not complete until this form and proof of income is received. You have 2 weeks from today to furnish acceptable proof of income. Until both the form and proof of income is received, we consider this an incomplete application request. Until the discount is approved, you are responsible for the full fee of the services received. If you have any questions, please contact Billing at 970-335-2342.

Your Legal FIRST Name	MI	Legal LAST Name		Date of Birth
Home Address (Number, Street)		City	State	Zip Code
Mailing Address (if different than Home)		City	State	Zip Code
Home Phone Number		Cell Phone Number	Are you Homeless?	Are you a Colorado Resident?

Instructions: List **EVERYONE LIVING IN YOUR HOME**. Even if You are Not Applying for Them. **Use More Paper if Necessary**

Relation to You	Legal First. MI., Last Name	Date of Birth	Axis Patient (Yes/No)
SELF			
Spouse/Significant Other:			
Child / Other			
Child / Other			
Child / Other			
Child / Other			
Child / Other			

INCOME

Unemployment Benefits. Retirement/Pension, Social Security Benefits, SSI, Survivor Benefits, SSDI, Veteran's Benefits, Dividends/Interest, Alimony, Child Support, Workers' Compensation, Disability benefits, Public Assistance, Railroad Retirement, Rental Income, In-Kind Income (Working for Rent), Other Cash Received Monthly

Person Getting Money	Getting Money From:	Monthly Amount (Before deductions)	
SELF			
Spouse/Significant Other:			
Child / Other			
Child / Other			
Child / Other			

Child / Other			

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Did you or anyone in your household file a Federal Income Tax Return Last Year?	Yes / No
Do you or anyone in your household plan to file a Federal Income Tax Return Next Year?	Yes / No
Do you have any type of insurance that will cover all or a portion of you medical expense?	Yes / No
If yes, Name of Your Insurance Company:	

This application is valid for 12 months. The patient must re-apply at least once a year. If the patient's financial situation changes significantly (e.g. loss of job, obtains employment, change in household, etc.) and/or receives additional insurance coverage after this application is approved but before 12 months has passed, the patient must inform Axis Health System and has the option to reapply for eligibility for the Sliding Fee Discount Program.

I have read and understand the Sliding Fee Discount Program and agree to comply with it. By signing this application, I authorize Axis Health System to confirm my income and family/household size. I verify that all information provided in determining eligibility is true and correct. I understand that providing false information or information subsequently determined to be false will result in all discounts being revoked and the full balance of the account(s) restored and payable immediately.

Completed by (Printed Patient/Responsible Person Name) Relationship to Patient

Signature *Please print this form and sign it by hand* Date

To be completed by AHS Staff:				
Carelogic Acct #		Intergy Acct#	Mediadent Acct #	
Date Rec'd:	by:		Date scanned:	
Date Rec'd- Billing:			Initials:	
Date POI Rec'd:	by:		Date scanned:	
Reminder call for POI (date)			By:	
Date POI received (Billing)			Initials:	
Household Size				
Frequency of Income: (weekly, biweekly, monthly…)				
Approved (Y, N)			Date:	
Level (1A, 2B, 3C, 4D, 5E)			End Date:	
Denied (Y, N)			Reason: (over income, non-resident, No POI…)	
SFNOM given on:				
Type of Patient Letter Sent:			Date Sent:	