TRIAD Health Systems Inc.

You might qualify for our sliding fee scale discount if:

1. **Your household income is below the amounts listed below**

Number in Household	Total Yearly Income	Number in Household	Total Yearly Income
1	$27,180	5	$64,940
2	$36,620	6	$74,380
3	$46,060	7	$83,820
4	$55,500	8	$93,260

2. **You fill out the "Sliding Fee Scale Application"**
   Applications are available on other side.

3. **You provide proof of income for the household.**
   Household size is defined as the total of all persons living at the address of the person making the application to the SFS program. If the applicant is living in a group home, household size will be one (other residents of the group home will not be included).

Proof of Household Income can include:

1. Current pay stub.
2. Most recent income tax return (Cannot be older than two years)
3. Annual Award Statement from Social Security
4. Social Security Disability, SSI or Pension showing on most recent bank statement
5. Letter from employer stating hourly wage and hours worked per week
6. Qualification Letter from Food Stamp Office
7. Letter from Person providing support to the applicant with amount of support

All forms **MUST** be completed with all required Documentation submitted before eligibility will be effective.

Partial applications cannot be processed.

Updated per 2022 Government Poverty Level

Sliding Fee Scale Application

Date:_____

Patient Name: _____ DOB: _____
Please Print

Total Household Members _____

Triad Health Systems, Inc. provides health care services for residents and employees of Gallatin, Carroll and Owen Counties. In order to insure that all residents and employees can continue to receive healthcare that they can access and afford we must bill patients based on their ability to pay.

(Read & initial each line)
I understand that deliberate misrepresentation by/of any household member may result in:

_____ All household members being exclude from the sliding fee scale program

_____ All sliding fee scale discounts received due to misrepresentation will be voided and payable by me.

_____ Prosecution under applicable Federal, State, and Local laws.

List **all** household members, regardless of age, and income for each. **Attach a copy of each type of income.** Examples of income are *(but not limited to):* Wages, Self-Employment, SSI, Child and/or Spousal Support, RSDI, Workers' Comp, Unemployment, Veterans Pension, Farm Income or Food Stamps

	Name	Date of Birth	Amt. $$	(W) Weekly (BM) Bi-monthly (BW) Bi-weekly (M) Monthly (Y) Yearly	Source of Income
1					
2					
3					
4					
5					
6					
7					
8					

Has this been the average income for the past 12 months? Yes No If no, please explain the differences.

_____

I certify the information given is true and correct. I also certify that I have reported all household income and agree to report any changes in household income. I understand that providing false information on this statement is subject to prosecution under Federal, State and/or Local law's, and can disqualify myself and all of my household members from the Sliding Fee Scale program.

I give Triad Health Systems, Inc. permission to obtain financial information for purposes of verification of household income.

Signature_____ Phone # _____

Address _____City _____ ST _____ Zip _____