PCS PRIMARY CARE SPECIALISTS

Charitable Assistance Application

Primary Care Specialist's policy is to provide essential health services regardless of the patient's ability to pay. Discounted fees are available. This application will help us identify the level of discount you may qualify to receive. Please be detailed.

Charitable Assistance/Sliding Fee Applications:
If approved at 100% of FPL, our nominal fee is: $10 per office visit. Discounted care should be paid in full at each visit.
For approved applications, discounts apply to office visits, physicals, procedures, and in-office lab and x-ray services.
Reference laboratory tests (Labcorp), Pathology, diagnostic ultrasound services, adult immunizations, EPS and Laser Center services are subject to exclusion. We are unable to apply our discount to any services ordered by PCS providers that are rendered at another facility (MRI, DEXA, hospital).

Charitable Assistance/Sliding Fee Requirements:
When applying for the Charitable Assistance program, patient identification and address must be provided. Acceptable methods include a valid driver's license, state ID card, employment, or other picture ID. A Social Security Number is needed for the application form and a copy of the SSN card is necessary. A copy of a Social Security card or birth certificate is required for under aged dependents.
A copy of the prior year's income tax return for each individual living in the household is required to verify income. If employment has changed since the filing of that return, copies of the last three months paycheck stubs or payroll records showing year-to-date earnings are required.
If the applicant has had no income for three months or more, this must be verified through some other official agency records, bank records, or by written statement from a landlord or other person outside the household having knowledge of the applicant's financial situation.

If You Feel You May Qualify:
Please complete a Charitable Assistance/Sliding Fee Program Application and return it to Primary Care Specialists. If you wish to apply the sliding fee to your current visit, your application will need to be returned within 45 days to allow for processing and approval. Approved applications are applied retro-actively 90 days.

Approval for Charitable Assistance/Sliding Fee Program:
You will be notified in writing when your application has been processed regarding your eligibility.
If we do not receive all information needed to process your application, we will notify you by mail what is needed. If we do not receive the completed information as requested or in a timely manner, your application will be denied.

Term of Charitable Assistance/Sliding Fee Program:
Once approved, your discount will be applied retro-active 90-days and will be valid for a term of nine (9) months. Please report any substantial change in household income during the approved period. Once the current application expires, you are eligible to reapply.

For questions contact our Billing office Monday thru Friday 208-234-2300 ext #102 #105 or #118

CHARITABLE ASSISTANCE APPLICATION

Patient Name:	Date of Birth:
Social Security Number:	Telephone number: Alternate number:
Current Physical Address:	
Current Mailing Address:	

Name of all residing in household	Date of Birth	Relationship	SSN	Employer	Applying for discount? YES	NO

If more room is needed for Children or Dependents please add them to the back of the form.

Income/Assets: YOU MUST PROVIDE INCOME/ASSET VERIFICATION.

Annual Household Income				
Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, disability, pension, annuity, veteran's benefits				
Alimony, child support, military family allotments, AFDC				
Unemployment, workers compensation, strike benefits, etc.				
Rent income, interest, dividends, and other income (student loans)				
Total income for the last twelve (12) months				

Savings	Checking	Investments/CDs	Retirement accounts	Total Assets
$	$	$	$	$

Do you have any insurance coverage for the Medical charge(s): Yes ________ No ________
If yes: Medicaid ________ Medicare ________ Private Insurance (Name) ____

Verification Checklist: (attach copies)	Yes	No
Identification Self/spouse: SS Card and Driver's license, birth certificate or employment ID		
Dependent verification: Birth Certificate, current tax records or court orders		
Income: Prior year tax return, three most recent pay stubs		
Insurance: Copy of Cards		
Medicaid: Application made or evidence or rejection		

I certify that the family size and household income information shown above is correct. I will supply copies of tax returns; pay stubs and other information verifying income may be required before a discount is approved. I agree to pay my portion of total charges for each service. I also agree to have a review of account every 6 months.

______________________________ ______________________________ ______________

Name (print) Signature Date

For office use only	
# Of Household members:	Approved ( ) Denied ( )
Annual Income:	
All Verification attached:	Qualified for: ( ) 30% ( ) 75%
Date Returned:	( ) 45% ( ) 85%
Date Approved:	( ) 65% ( ) 100%