



## Sliding Fee Discount Application

It is the policy of Tueller Counseling Services, Inc. & Unified HealthCare of Idaho to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this facility or one of our other agency locations (Idaho Falls, Rigby, and Rexburg), but not those services or equipment that are purchased from outside, including referenced psychological testing, hospitalization, reference laboratory testing, drugs, and ex-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

<b>Name of Head of Household</b>			<b>Place of Employment</b>	
<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Phone</b>

Please list spouse and dependents under age 18.

<b>Name</b>	<b>Date of Birth</b>	<b>Name</b>	<b>Date of Birth</b>
<b>Self</b>		<b>Dependent</b>	
<b>Spouse</b>		<b>Dependent</b>	
<b>Dependent</b>		<b>Dependent</b>	
<b>Dependent</b>		<b>Dependent</b>	

### Annual Household Income

<b>Source</b>	<b>Self</b>	<b>Spouse</b>	<b>Other</b>	<b>Total</b>
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents royalties, income from estates, trusts, education assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
<b>Total Income:</b>				

**NOTE:** Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I \_\_\_\_\_ (print name) certify that the family size and income information shown above is correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Office Use Only**

Patient Name: \_\_\_\_\_

Approved Discount: \_\_\_\_\_

Approved By: \_\_\_\_\_ & \_\_\_\_\_

Date Approved: \_\_\_\_\_

Verification Checklist	Yes	No
Identification/Address: Driver’s License, Utility Bill, Employment ID or Other. (A picture ID may be obtained through the Department of Health & Welfare.)		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		