MARIMNHEALTH
COEUR D'ALENE TRIBE

Sliding Fee Qualifications

- Proof of Income (tax information, paycheck stub, bank statement, etc.)
- Proof of Residency (must be your physical address, cannot be a P.O. Box)

Applicants must live within one of the following zip code areas:

IDAHO	IDAHO	WASHINGTON
83802 - Avery	83844 - Moscow	99012 - Fairfield
83806 - Bolvill	83851 - Plummer	99018 - Latah
83808 - Calder	83855 - Onaway	99030 - Rockford
83812 - Clarkia	83857 - Princeton	99033 - Tekoa
83823 - Deary/Helmer	83861 - Saint Maries	99128 - Farmington
83824 - Desmet	83866 - Santa	99130 - Garfield
83830 - Fernwood	83870 - Tensed	99158 - Oakesdale
83801 - Athol	83871 - Troy	99161 - Palouse
83834 - Harvard	83872 - Viola	99170 - Rosalia
83843 - Moscow	83876 - Worley	
83833 - Harrison	83855 - Potlatch	
83842 - Medimont		

There is no residency requirement for those patients who are married to or the children of a registered patient who is receiving Indian Health Funding for clinic visits. To prove this, please send a marriage certificate.

SERVICE RESTRICTIONS

- That patient must be seen by a Marimn Health provider.
- Dental is limited to preventative and restorative procedures only. Services that require a lab fee, such as crowns and bridges, are not covered.
- Pharmacy items are restricted to a specific drug list. Patients may have to pay full price for their prescription items. Outside prescriptions will be honored only if referred by a Marimn Health provider.
- Elective procedures, such as wart removals and vasectomies, may not be covered. Please contact the Revenue Department for details: 208-686-1931 Ext 276.
- Referral labs are not covered. You will receive a bill from the referral lab at your sliding percentage.
- Applications must be screened for Idaho Medicaid eligibility.
- Discounts may be available regardless of insured status.

Sliding Fee Program Payment Contract

The Sliding Fee Program is a part of our Community Health Grant which allows Marimn Health to offer services at a discounted rate to patients who meet the qualifications. It is federally funded, and so has some requirements that must be met by participants to stay in the program.

This is a contract between the participant and Marimn Health. Marimn Health Medical Center agrees to provide covered services at a fixed, discounted rate to participants. Those rates are as follows:

SLIDING FEE	MEDICAL & BEHAVIORAL HEALTH	DENTAL	PHARMACY
Nominal	$10.00	$25.00	$5.00 per prescription
25%	$20.00	$50.00	$10.00 per prescription
50%	$40.00	$75.00	$15.00 per prescription
75%	$60.00	$100.00	$20.00 per prescription

If you have insurance, the lesser of your co-pay, deductible or sliding fee payment will be billed to you. Payment must be received within 30 days of being billed or your account will be deemed past due. Services done outside of Marimn Health Medical Center are not included in this payment and may be billed to the patient by the rendering provider.

The patient or guarantor agrees to pay the required payment prior to receiving covered services at the Marimn Health Medical Center. The patient also agrees that if the required payment is not made they will not receive the scheduled service (except in cases of life threatening accident or illness, as determined by the clinical staff at Marimn Health) and will be required to reschedule. There will be no exceptions.

The patient or guarantor also agrees that their account must be current with no past due balances. If the account is not current, then the participant will be taken off of the Sliding Fee Program and be required to pay full price for any services received. They will also not be eligible for reinstatement in the program until their account is current.

I have read and understand the above information and I agree to all terms and conditions of this agreement. I also understand this contract is in effect for only 12 months. It is possible to update sooner if there is a change in income.

This contract is subject to change without notice when changes are made due to grant requirements.

SIGNATURE: _____ DATE: _____

P: 208.686.1931 F: 208.686.0213 marimnhealth.org PO Box 388 | 427 N. 12th Street | Plummer, ID 83851

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Sliding Fee Application

MR #: _____ Applicant: _____ Birth Date: _____ / _____ / _____

Physical Address: _____

_____

(city) (state) (zip)

Mailing Address (if different than above): _____

_____

(city) (state) (zip)

Home Phone: (__) _____ - _____ Cell Phone: (____) _____ - _____

Employer Name: _____ Phone: ( ) _____ - _____

MR #: _____ Applicant's Spouse: _____ Birth Date: ___ /_____ / _____

Spouse's Employer Name: _____ Phone: (___) ____ - _____

Gross Annual Income from All Sources (please specify): _____

Please list any other members of your household (if you need more room, please use the back of this page):

	Name:	Relationship:	Birth Date:	Employed?
MR #: _____				
MR #: _____				
MR #: _____				
MR #: _____				

SIGNATURE: _____ DATE: _____

MEDICAID SCREENING

If any family member can answer yes to any of these questions, they may be eligible for Medicaid assistance. Please circle any that may be applicable or contact Molly Schnebly at 208-686-1931 ext 273.

1. Pregnant, either currently or in the last 60 days
2. Any family member over the age of 65 or under the age of 19
3. Any family member that is disabled

Front Desk Staff Only:
□ Bad Debt _____ □ Balance _____ □ Annual Income _____

□ Zip Code _____ □ Marriage Certificate □ NextGen □ Pioneer Rx Initials: _____

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