HOT SPRINGS HEALTH

THERMOPOLIS CLINIC • WORLAND CLINIC • RIVERTON CLINIC • SHOSHONI CLINIC

NOTICE TO PATIENTS:
This practice serves all patients regardless of the inability to pay. Discounts for essential services are offered based on family size and income. If you would like additional information please ask.
Thank you

AVISO A LOS PACIENTES:
Esta práctica sirve a todos los pacientes independientemente de la incapacidad de pago.Los descuentos por servicios esenciales se ofrecen en función del tamaño de la familia y los ingresos. Si desea información adicional, por favor pregunte. Gracias

HOT SPRINGS HEALTH- FAMILY PRACTICE CLINICS

DISCOUNT MEDICAL FEE PROGRAM POLICY

POLICY
It is the policy of Hot Springs health Family Practice Clinics to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon household income and size. A sliding fee schedule is used to calculate the basic discount and it will be updated each year using the federal poverty guidelines. A minimum payment o $3.65 will be required for all office visits. Once approved, the discount will be in effect for one year, after which the patient must reapply.

DISCOUNT APPLICATION PROCESS
A completed application, including supporting documentation of household income and insurance coverage must be submitted. Adults living in homes with others must include income for all those within the household that contribute support to the applicant.
Required documentation includes a complete application, prior year's income tax return, the last three pay stubs, copy of insurance cards, and any other form of documented income. Any insurance or insurance reimbursement programs must be disclosed to Hot Springs Health Family Practice. Zero income responses must include detailed reasoning. Failure to provide proper documentation within 30 days will results in the application being denied.

SERVICES COVERED
The discount will apply to all medical services provided in the Hot Springs Health Family Practice Clinics. Office visits will be limited to three per month. Additional visits will be approved based upon the individual provider's discretion.

2025 FEDERAL POVERTY GUIDELINES

Family Size	100% ADJ Minus $3.65 Copay	Pay 15%	85% ADJ	Pay 35%	65% ADJ	Pay 50%	50% ADJ	Pay 66%	34% ADJ
1	**15,650**	15,651	**23,475**	23,476	**31,300**	31,301	**39,125**	39,126	**46,950**
2	**21,150**	21,151	**31,725**	31,726	**42,300**	42,301	**52,875**	52,876	**63,450**
3	**26,650**	26,651	**39,975**	39,976	**53,300**	53,301	**66,625**	66,626	**79,950**
4	**32,150**	32,151	**48,225**	48,226	**64,300**	64,301	**80,375**	80,376	**96,450**
5	**37,650**	37,651	**56,475**	56,476	**75,300**	75,301	**94,125**	94,126	**112,950**
6	**43,150**	43,151	**64,725**	64,726	**86,300**	86,301	**107,875**	107,876	**129,450**
7	**48,650**	48,651	**72,975**	72,976	**97,300**	97,301	**121,625**	121,626	**145,950**
8	**54,150**	54,151	**81,225**	81,226	**108,300**	108,301	**135,375**	135,376	**162,450**

Please provide copies of the following documentation:
(If you need copies printed the clinic can assist you)

- Driver's license
- Prior year's income tax return
- Last three pay stubs
- Last three bank statements
- Detailed reasoning for zero income responses

ALL REQUIRED DOCUMENTATION MUST BE RECEIVED WITHIN 30 DAYS FOR CONSIDERATION.

DISCOUNT MEDICAL FEE PROGRAM APPLICATION

Head of Household _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Date of Birth_____ SSN _____

Place of Employment_____

Work phone _____

Health Insurance Plan and Number _____

Spouse Name _____

Address _____

City _____ State_____ Zip Code _____

Home Phone _____ Cell Phone _____

Date of Birth_____ SSN _____

Place of Employment_____

Work phone _____

Health Insurance Plan and Number _____

Additional Adults living in the home (include with income documentation)

Name_____ Relationship _____

DOB_____ SSN _____

Please list dependents under 18 years of age

Name Date Of Birth SSN

_____

_____

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_____

Income Source	Self	Spouse	Other (people in the household)	TOTAL
Gross wages, salaries, tips etc.				
Social Security, Pension, VA				
Alimony, Child Support				
Income Self Employment				
Unemployment				
Worker Compensation				
Rental, Interest, other income				
TOTAL Income				

I certify that the information shown above is correct and understand verification is required for approval. I understand that if all requested documentation is not provided or is not valid my application may be denied.

_____

Printed Name and Date

_____

Signature and Date

Office use Only: Approved or Denied Signature and Date_____