ADAMS COUNTY HEALTH CENTER INC.
Working Together to Improve Lives in Our Communities

205 North Berkley – Council Idaho 83612 - Phone: 208-253-4242 - FAX: 208-253-6849

RETURN FORMS TO: P.O Box 428 Council, ID 83612 or laurenr@achcid.org

ATTENTION SLIDING FEE PATIENTS

ALL SLIDING FEE PATIENTS ARE REQUIRED TO PAY YOUR NOMINAL CHARGE/MINIMUM PAYMENT AT THE TIME SERVICE IS PROVIDED.

SLIDING FEE DISCOUNTS (SFD) APPLY ONLY TO ORDERS OR SERVICES, WRITTEN AND RENDERED, BY ADAMS COUNTY HEALTH CENTER INC. IN-HOUSE PROVIDERS.

ADAMS COUNTY HEALTH CENTER INC.

2026 Sliding Fee Discount Program Schedule

ANNUAL INCOME[1] – Thresholds by Sliding Fee Discount Pay Class and Percentage of Poverty

ANNUAL INCOME												
Category		1		2		3		4		5		
Charge		Nominal Charge (N.C)		Minimum Payment + 20% of Charge		Minimum Payment + 40% of Charge		Minimum Payment + 60% of Charge		Minimum Payment + 80% of Charge		100%
FPG		At or Below 100%		101-125%		126-150%		151-175%		176-200%		Over 200%
Pharmacy Fee		Cost + $16.50		Cost + $17.50		Cost + $18.50		Cost + $19.50		Cost + $20.50		
household size	1	$0	$15,960	$15,961	$19,950	$19,951	$23,940	$23,941	$27,930	$27,931	$31,920	>$31,921
	2	$0	$21,640	$21,641	$27,050	$27,051	$32,460	$32,461	$37,870	$37,871	$43,280	>$43,281
	3	$0	$27,320	$27,321	$34,150	$34,151	$40,980	$40,981	$47,810	$47,811	$54,640	>$54,641
	4	$0	$33,000	$33,001	$41,250	$41,251	$49,500	$49,501	$57,750	$57,751	$66,000	>$66,001
	5	$0	$38,680	$38,681	$48,350	$48,351	$58,020	$58,021	$67,690	$67,691	$77,360	>$77,361
	6	$0	$44,360	$44,361	$55,450	$55,451	$66,540	$66,541	$77,630	$77,631	$88,720	>$88,721
	7	$0	$50,040	$50,041	$62,550	$62,551	$75,060	$75,061	$87,570	$87,571	$100,080	>$100,081
	8	$0	$55,720	$55,721	$69,650	$69,651	$83,580	$83,581	$97,510	$97,511	$111,440	>$111,441
Note: for families/households with more than 8 persons, add $5,680 for each additional person												

MONTHLY INCOME – Thresholds by Sliding Fee Discount Pay Class and Percentage of Poverty

MONTHLY INCOME												
Category		1		2		3		4		5		
Charge		Nominal Charge (N.C)		Minimum Payment + 20% of Charge		Minimum Payment + 40% of Charge		Minimum Payment + 60% of Charge		Minimum Payment + 80% of Charge		100%
FPG		At or Below 100%		101-125%		126-150%		151-175%		176-200%		Over 200%
Pharmacy Fee		Cost + $16.50		Cost + $17.50		Cost + $18.50		Cost + $19.50		Cost + $20.50		
household size	1	$0	$1,330	$1,331	$1,663	$1,664	$1,995	$1,996	$2,328	$2,329	$2,660	>$2,661
	2	$0	$1,803	$1,804	$2,254	$2,255	$2,705	$2,706	$3,156	$3,157	$3,607	>$3,608
	3	$0	$2,277	$2,278	$2,846	$2,847	$3,415	$3,416	$3,984	$3,985	$4,553	>$4,554
	4	$0	$2,750	$2,751	$3,438	$3,439	$4,125	$4,126	$4,813	$4,814	$5,500	>$5,501
	5	$0	$3,223	$3,224	$4,029	$4,030	$4,835	$4,836	$5,641	$5,642	$6,447	>$6,448
	6	$0	$3,697	$3,698	$4,621	$4,622	$5,545	$5,546	$6,469	$6,470	$7,393	>$7,394
	7	$0	$4,170	$4,171	$5,213	$5,214	$6,255	$6,256	$7,298	$7,299	$8,340	>$8,341
	8	$0	$4,643	$4,644	$5,804	$5,805	$6,965	$6,966	$8,126	$8,127	$9,287	>$9,288
Note: for families/households with more than 8 persons, add $473.33 for each additional person												

2026 FPG published 1/13/2026 by the Federal Register for Health and Human Services
https://aspe.hhs.gov/poverty-guidelines

Board Approval: 2019/07/31, 2020/1/22, 2021/1/27, 2022/2/23, 2023/1/25, 2024/1/24, 2025/1/29, 2026/1/28

Charge Schedule		
Service Category	**Nominal Charge (>100% FPG)**	**Minimum Payment (101-200% FPG**
Medical	$25	$25 plus % of Charge
Procedure	$25	$25 plus % of Charge
Dental – Preventive service	$60	$60 plus % of Charge
Procedure	$60	$60 plus % of Charge
Emergency	$60	$60 plus % of Charge
Behavioral Health	$25	$25 plus % of Charge
Optometry	$60	$60 plus % of Charge
Procedure	$60	$60 plus % of Charge
Lab	$25	$25 plus % of charge
X-ray	$25	$25 plus % of charge
Physical Therapy	$25	$25 plus % of charge
Pharmacy	Category 1	Category 2 – Category 5

	What Do I Owe?								
		Services							
	FPG	**Pharmacy**	**Medical**	**In-House Lab**	**In-House X-Ray**	**Behavioral Health**	**Physical Therapy**	**Dental**	**Optometry**
1	0-100%	Cost + $16.50	$25					$60	
2	101-125%	Cost + $17.50	$25 + 20% of charges					$60 + 20% of charges	
3	126-150%	Cost + $18.50	$25 + 40% of charges					$60 + 40% of charges	
4	151-175%	Cost + $19.50	$25 + 60% of charges					$60 + 60% of charges	
5	176-200%	Cost + $20.50	$25 + 80% of charges					$60 + 80% of charges	

Adult vaccines and durable medical equipment (ie: braces, slings, splints) are not covered under the sliding fee discount program.

Board Approval: 2019/07/31, 2020/1/22, 2021/1/27, 2022/2/23, 2023/1/25, 2024/1/24, 2025/1/29, 2026/1/28

FINANCIAL ASSISTANCE APPLICATION

ADAMS COUNTY HEALTH CENTER INC.

Date of Request	
Patient Name	
Mailing Address	
Physical Address	
Phone Number	
Number of Persons Residing in household	

Adams County Health Center Inc., (ACHC) defines a family household member as anyone including self, spouse, or partner; any dependent children under 18 years of age; and anyone within the residence that the head of household provides support for. Please list yourself and all the members of your family you wish to include in your household size.

ACHC uses your monthly gross income or your annual gross income to determine eligibility for discounted services. The following documentation is required for eligibility. Approved proof of identity, address, and income sources includes one or more of the following items:

- Adult identification: may include a driver's license, identification card or social security card
- Minor identification: may include a birth certificate, identification card or social security card
- Paycheck stubs with year-to-date information
- Most recent tax return
- Bank statements
- Statement of income determinations from federal, State, or local government (such as SSI letter)
- ACHC's *No Proof of Income Worksheet*
- ACHC's *Homeless Eligibility Application* with *No Proof of Income Worksheet*
- A utility bill showing current address.

Household Member Name	Date of Birth	Relationship to Applicant	Monthly Income
		Self	$
			$
			$
			$
			$
			$
			$
			$
		Total Family/Household Income	**$**

Board Approval: 2019/07/31, 2020/1/22, 2021/1/27, 2022/2/23, 2023/1/25, 2024/1/24, 2025/1/29, 2026/1/28

FINANCIAL ASSISTANCE APPLICATION, CONT.

I certify that the information given on this form and the income provided is complete, true, and correct. If I do not qualify for financial assistance, I agree to pay the outstanding balance in full, or set up payment arrangements. I agree and understand that any remaining balance not paid through financial assistance will be my responsibility. I understand that the financial assistance will expire one year or twelve (12) months on or before the date indicated below and I will be required to reapply. If there is a change in income, I will submit a new Financial Assistance Application. You will receive a letter in the mail stating eligibility.

Signature: _____

Date: _____

----------To be completed by ACHC staff only----------

Patient Has Qualified For the Following Discount						
☐ Does Not Qualify	☐ Category 1	☐ Category 2	☐ Category 3	☐ Category 4	☐ Category 5	☐ No Proof of Income

Financial Assistance Approved Until (Date): _____

Thank you for choosing Adams County Health Center Inc., as your healthcare provider. If you have any questions regarding the Sliding Fee program, please contact Adams County Health Center Inc.'s Sliding Fee Coordinator at 208-253-4242 ext. 1017.

Board Approval: 2019/07/31, 2020/1/22, 2021/1/27, 2022/2/23, 2023/1/25, 2024/1/24, 2025/1/29, 2026/1/28

HOMELESS ELIGIBILITY APPLICATION

ADAMS COUNTY HEALTH CENTER INC.

Patient Status *Check One*		**Date:**		**MR#:**	
	New Patient				
	Established Patient				

Name:						
Date of Birth:		**Social Security Number:**				
Phone:		**Marital Status:** *Check One*		Single		Divorced
				Married		Widowed

My present living conditions lack a fixed, regular, and adequate nighttime residence and I have primarily nighttime residence that is: *(Check One)*

	A supervised publicly or privately-operated <u>shelter</u> designated to provide temporary living accommodation (including welfare hotels, congregate shelters, and transitional housing)
Specify Place:	
	A residence/that provides a temporary housing for individuals and their families.
Specify Place:	
	Another public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for individuals.
Specify Place:	

I certify that I am homeless and do not have the resources to obtain housing for the following reasons:

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HOMELESS ELIGIBILITY APPLICATION, CONT.

I certify that the information given on this form is complete, true and correct. If found to be untruthful, I understand that access to Adams County Health Center Inc. may be restricted. I understand that the financial assistance will expire on the date listed on the Financial Assistance Application and I will be required to reapply. If there is a change in income, I will submit a new Financial Assistance Application.

Patient Signature: _____

Date: _____

Board Approval: 2019/07/31, 2020/1/22, 2021/1/27, 2022/2/23, 2023/1/25, 2024/1/24, 2025/1/29, 2026/1/28

NO PROOF OF INCOME WORKSHEET

ADAMS COUNTY HEALTH CENTER INC.

Patient Status *Check One*		**Date:**		**MR#:**				
	New Patient							
	Established Patient							
Name:								
Date of Birth:		**Social Security Number:**						
Phone:		**Marital Status:** *Check One*		Single		Divorced		
				Married		Widowed		

Have you applied for Medicare, Medicaid, Primary Care Network (PCN), or Children's Health Insurance Program (CHIP)? *(Check One)*		**Yes**
		No

Who provides financial support for you?	
Name:	
Relationship:	
Address:	
Phone Number:	

Patient Signature: _____

Date: _____

Board Approval: 2019/07/31, 2020/1/22, 2021/1/27, 2022/2/23, 2023/1/25, 2024/1/24, 2025/1/29, 2026/1/28

The following should be filled out by the person providing financial support OR self-declaration

Patient fees are based on the type of service provided and the patient's income and household size. If our patient has listed, you as the person who is financially supporting them. Please answer the following questions. If this is a self-declaration, please complete the statement below.

How long has the patient been living with you?	*Years*		*Months*	
How much financial support did you provide last month? (i.e., rent, utilities, food, etc.)				**$**
Provide a brief description of the situation:				

Patient or Supporter Signature: _____

Date: _____

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