INFANT WELFARE SOCIETY of CHICAGO
a community health center

Sliding Fee Discount Application

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.
Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Retirement Pension					
Child Support, Alimony					
Interest Income					
Unemployment					
Rentals					
Other					
				TOTAL	**$**

ATTENTION: If income verification is not provided on the day of application, you must provide it within 14 days of the application in order for the sliding fee to be applied retroactively to your visit. Failure to provide income verification within the 14 days will result in the denial of your application and the cost of the visit will be solely your responsibility.

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IWS Fee Scale for Medical, Behavioral Health and CHAT Services
Schedule of Discounts
SFY2016
as of 8/1/2016

Poverty level	100%	101% to 138%	139% to 175%	176% to 213%	214% to 250%	251% and greater
**Total Fee	$30	35%	45%	65%	85%	100%
Family Size	Annual Income	Annual Income	Annual Income	Annual Income	Annual Income	Annual Income
1	$11,770	$11,771 to $16,243	$16,244 to $20,598	$20,599 to $25,070	$25,071 to $29,425	29426 and above
2	$15,930	$15,931 to $21,983	$21,984 to $27,878	$27,879 to $33,931	$33,932 to $39,825	39826 and above
3	$20,090	$20,091 to $27,724	$27,725 to $35,158	$35,159 to $42,792	$42,793 to $50,225	50226 and above
4	$24,250	$24,251 to $33,465	$33,466 to $42,438	$42,439 to $51,653	$51,654 to $60,625	60626 and above
5	$28,410	$28,411 to $39,206	$39,207 to $49,718	$49,719 to $60,513	$60,514 to $71,025	71026 and above
6	$32,570	$32,571 to $44,947	$44,948 to $56,998	$56,999 to $69,374	$69,375 to $81,425	81426 and above
7	$36,730	$36,731 to $50,687	$50,688 to $64,278	$64,279 to $78,235	$78,236 to $91,825	91826 and above
8	$40,890	$40,891 to $56,428	$56,429 to $71,558	$71,559 to $87,096	$87,097 to $102,225	102226 and above
9	$45,050	$45,051 to $62,169	$62,170 to $78,838	$78,839 to $95,957	$95,958 to $112,625	112626 and above
10	$49,210	$49,211 to $67,910	$67,911 to $86,118	$86,119 to $104,817	$104,818 to $123,025	123026 and above
11	$53,370	$53,371 to $73,651	$73,652 to $93,398	$93,399 to $113,678	$113,679 to $133,425	133426 and above
12	$57,530	$57,531 to $79,391	$79,392 to $100,678	$100,679 to $122,539	$122,540 to $143,825	143826 and above

For families with more than 12 persons, add $4,160 for each additional person.

To apply for a sliding fee discount, please ask one of our staff for a Sliding Fee Discount Application.

Optometry Services Fee:	$ 60.00	
Dental Services Fee:	$ 60.00	**Only for exam and cleaning. Other dental services are a fee-for -services based on Medicaid reimbursement.**

IDHS Family Planning Program -
Schedule of Discounts
SFY2015 - 20% Breaks

	I	II	III	IV	V	VI
Total Fee	0%	20%	40%	60%	80%	100%
Family Size	Annual Income	Annual Income	Annual Income	Annual Income	Annual Income	Annual Income
1	11,770	11771 to 16243	16244 to 20598	20599 to 25070	25071 to 29425	29426 and above
2	15,930	15931 to 21983	21984 to 27878	27879 to 33931	33932 to 39825	39826 and above
3	20,090	20091 to 27724	27725 to 35158	35159 to 42792	42793 to 50225	50226 and above
4	24,250	24251 to 33465	33466 to 42438	42439 to 51653	51654 to 60625	60626 and above
5	28,410	28411 to 39206	39207 to 49718	49719 to 60513	60514 to 71025	71026 and above
6	32,570	32571 to 44947	44948 to 56998	56999 to 69374	69375 to 81425	81426 and above
7	36,730	36731 to 50687	50688 to 64278	64279 to 78235	78236 to 91825	91826 and above
8	40,890	40891 to 56428	56429 to 71558	71559 to 87096	87097 to 102225	102226 and above
9	45,050	45051 to 62169	62170 to 78838	78839 to 95957	95958 to 112625	112626 and above
10	49,210	49211 to 67910	67911 to 86118	86119 to 104817	104818 to 123025	123026 and above
11	53,370	53371 to 73651	73652 to 93398	93399 to 113678	113679 to 133425	133426 and above
12	57,530	57531 to 79391	79392 to 100678	100679 to 122539	122540 to 143825	143826 and above

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Revised on 6/22/2016

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I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Infant Welfare Society of Chicago if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Infant Welfare Society of Chicago. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Name (Print):_____

Signature:_____

Internal use only

Sliding Fee:

Medical: _____ CHAT:_____ Therapy: _____

Dental: $60.00 Optometry: $60.00 Family Planning: _____

Proof of income provided (circle all that apply):

1. Most recent tax returns (all pages)
2. Current pay stubs (last 4 weeks)
3. Letter from the employer on their letterhead stating your gross earnings
4. Unemployment letter
5. Social Security earning statement
6. Self-employment form

Effective date: _____ Expiration date: _____

_____
Patient Signature

_____
Signature of staff making eligibility determination

Revised on 6/22/2016