Challis Area Health Center

March 2024

Dear Patient,

On April 30, 2024, your current enrollment in the Challis Area Health Center's Sliding Discount Program will expire. You are required to reapply for the program for continued enrollment. If you do not reapply, your benefits will terminate effective May 1, 2024. You will not be eligible for discount services until you reapply.

Challis Area Health Center's Sliding Fee Discount co-pays range from $25 to $70 a visit, depending on income and household size. The Sliding Discount co-pay is DUE at time of service.

To reapply, please call CAHC's Community Health Worker, Rose Cheff, at 208-879-3051 to schedule an appointment (M-W, 7:30 a.m. to 1:00 p.m.). You can also mail your application in, along with copies of the required financial documents. Please include your phone number so we can follow up with you.

When you come in, please provide the following information for each person in your household:

- DOB or age of all residents
- Proof of income for ALL people residing with you

Documents for proof of income include:

- 2023 Tax returns
- Past 3 months' paycheck stubs
- Past 3 months' bank statements

You may complete a Self-Declaration form if you are unable to provide the information referenced above.
Mail completed application to:

Challis Area Health Center
PO Box 980
Challis, ID 83226

Sincerely,
Challis Area Health Center
2024/2025

Challis Area Health Center

SLIDING DISCOUNT APPLICATION

Thank you for choosing Challis Area Health Center (CAHC) as your healthcare provider. CAHC bases its Sliding Discount Schedule on income and household size. **INCOME** includes wages and salaries before any deductions are made; or net receipts from self-employment, Social Security (taxable and non-taxable payments from Social Security are defined as income), retirement, unemployment, worker's compensation, veteran's payments, stipends, alimony, child support, pensions, etc. Food Stamps are not considered income. **HOUSEHOLD** is 1) all persons residing together; and 2) supported by a common income or set of incomes. The household may include temporarily absent individuals (away at school) but does not include those being supported by 'another' (in a correctional facility or with the 'other' parent). **For all individuals counted as part of the household, their income must also be included. Please complete the following table:**

Household Member Name (Last, First)	DOB/ Age	Relationship to Applicant	Annual Income	Income Documented Y/N?
		Total Family/Household Income:		

I certify the above information and the provided documentation is complete, true, and correct to the best of my knowledge. I understand and agree to pay any amount I do not qualify to have discounted. If any insurance, income, or household circumstances change, I will notify CAHC.

Patient Signature:_____ **Date:**_____
Employee Verifying Signature:_____ **Date:**_____

You have qualified for the following discount:

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<100%	100%-125%	125%-150%	150%-175%	175%-200%	>200%
$25	$40	$50	$60	$70	

Challis Area Health Center

SELF-DECLARATION FORM

Name:	
Date of Birth:	
Contact Phone:	**Marital Status: Single Married Divorced Widow**
Have you applied for Medicare, Medicaid, or Children's Health Insurance Program? YES NO	
What is your monthly/annual income?	
What is the source of your income? (Job? Unemployment? Social Security?)	
What is your source of food?	
What is your source of shelter?	
Provide a summary of your current situation. Jobless? New to the area? Unable to purchase insurance? Other issues?	

I certify that the information given on this form is complete, true, and correct to the best of my knowledge. If the information is found to be false, I understand that access to the Challis Area Health Center may be terminated.

Patient Signature:_____***Date:***_____

Challis Area Health Center

Program, Rules, Guidelines, Limitations & Patient Agreement

You have a co-pay of $_____ that is required at check in for every appointment.
(Note: Your co-pay is determined after our application is reviewed by CAHC Staff.)

Your co-pay is due for every day that services are performed at CAHC. Payment is due at time of service. If you do not pay your co-pay, you may be billed at full price. Services performed by CAHC are covered under the discount program. If you have labs that are processed by Quest, you will be billed by Quest. If you have an x-ray, you will be billed by the radiologist who interprets the x-ray. **The ambulance/EMT, Life Flight, and related services are not covered under this program.**

As a CAHC patient and participant in the Sliding Discount Program, you automatically qualify for the 340B program. The 340B program is a federal program that requires drug manufacturers to provide outpatient drugs to eligible healthcare organizations at significantly reduced prices. You will receive a 340B Discount Card after your application is approved by CAHC Staff. Only prescriptions issued by a CAHC provider are eligible for the 340 pricing; 340B drug pricing does not apply to all prescription medications. The 340B Discount Card only works at Bengal Pharmacy in Challis and Pocatello.

You are required to re-apply annually for continued participation in the Sliding Discount Program. You are required to provide updated financial information annually for continued participation in the program. Your enrollment ends April 30th of each year. Your discount will not be valid after that date. It is your responsibility to complete the application and provide all required documents to re-enroll. You can complete the application and mail it, along with a copy of your financial documents, to:

Challis Area Health Center
PO Box 980
Challis, ID 83226

Or you can call 208-879-4351 and make an appointment to meet with our Community Health Worker, Rose Cheff, to complete the paperwork. Patients mailing applications will receive a call from Rose regarding application approval.

PLEASE COMPLETE THE SCALE BELOW

On a scale of 1 to 5, do you feel the nominal fee for this program is a barrier to care for you or your family?

(Affordable) 1 2 3 4 5 (Unaffordable)

I hereby affirm that the information provided on this application is correct to the best of my knowledge. I agree that any misleading, falsified information and/or omissions will terminate my enrollment and may disqualify me for participation in the Sliding Discount Program. I may be subject to penalties under Federal Laws, including fines and imprisonment. I agree to comply with all terms, rules and guidelines of the Sliding Fee Discount Program and agree to report any significant changes in my income to the Challis Area Health Center.

By signing below, you are stating that you understand the rules of the program and agree to abide by them.

Patient Signature:_____ **Date:**_____

Employee Signature:_____ **Date:**_____

Sliding Discount Schedule 2024/25

Household Size	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	NOT ELIGIBLE
1	$0.00 - $15,060.00	$15,060.01 - $18,825.00	$18,825.01 - $22,590.00	$22,590.01 - $26,355.00	$26,355.01 - $30,120.00	≥ $30,120.01
2	$0.00 - $20,440.00	$20,440.01 - $25,550.00	$25,550.01 - $30,660.00	$30,660.01 - $35,770.00	$35,770.01 - $40,880.00	≥ $40,880.01
3	$0.00 - $25,820.00	$25,820.01 - $32,275.00	$32,275.01 - $38,730.00	$38,730.01 - $45,185.00	$45,185.01 - $51,640.00	≥ $51,640.01
4	$0.00 - $31,200.00	$31,200.01 - $39,000.00	$39,000.01 - $46,800.00	$46,800.01 - $54,600.00	$54,600.01 - $62,400.00	≥ $62,400.01
5	$0.00 - $36,580.00	$36,580.01 - $45,725.00	$45,725.01 - $54,870.00	$54,870.01 - $64,015.00	$64,015.01 - $73,160.00	≥ $73,160.01
6	$0.00 - $41,960.00	$41,960.01 - $52,450.00	$52,450.01 - $62,940.00	$62,940.01 - $73,430.00	$73,430.01 - $83,920.00	≥ $83,920.01
7	$0.00 - $47,340.00	$47,340.01 - $59,175.00	$59,175.01 - $71,010.00	$71,010.01 - $82,845.00	$82,845.01 - $94,680.00	≥ $94,680.01
8	$0.00 - $52,720.00	$52,720.01 - $65,900.00	$65,900.01 - $79,080.00	$79,080.01 - $92,260.00	$92,260.01 - $105,440.00	≥ $105,440.01
Each additional person	$0.00 - $5,380.00	$5,380.01 - $6,725.00	$6,725.01 - $8,070.00	$8,070.01 - $9,415.00	$9,415.01 - $10,760.00	≥ $10,760.01

Sliding Flat Fee	Nominal Charge	Flat Fee	Flat Fee	Flat Fee	Flat Fee	Actual Charges
	$25.00	$40.00	$50.00	$60.00	$70.00	

Effective 1/11/2024