



Insight and Empowerment, LLC
1908 Jennie Lee Drive, Idaho Falls, ID 83404
(208) 932-7048 phone
(208) 970-6188 fax
IE@insightandempowerment.com

**Sliding Fee Scale Application
2026 Federal Poverty Guidelines**

Instructions:

1. Only use dark blue or black ink when filling out the application.
2. Fill out the application completely and return within 10 days to Insight and Empowerment.
3. This application can be dropped off at our location or e-mailed to IE@insightandempowerment.com, faxed to (208) 970-6188 or mailed to the address: 1908 Jennie Lee Drive, Idaho Falls, ID 83404.
4. You must attach proof of income for the last 30 days; verifications for consideration.

Responsible Party: _____

Address: _____

Telephone: _____

DOB: _____

SSN: _____

Family Size: _____

Please list each family member who lives in your household. This includes parents and children, but not extended family members.

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

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Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Please list each family members current employer and fill out all fields related to that person's employment. If your family household has NO earnings, please initial here: _____

Employer Name: _____ Frequency Paid: _____

Employer Name: _____ Frequency Paid: _____

Do you or anyone in your family household receive any income from the following sources, and if so, how much per month?

Social Security Retirement/Disability/Survivors? _____

Unemployment/Workman’s Compensation? _____

Child Support/Alimony? _____

Other? _____

1. I certify that the information provided here is true, complete, and accurate.
2. I give Insight and Empowerment, LLC permission to share my information with other organizations, grantors, or providers (and their auditors) that provide discounted services.
3. I understand intentionally providing false information may exclude me from receiving discounted services at Insight and Empowerment, LLC. I may be billed for any discounts I received with false information. I understand that I must provide verification of income or updates to income.
4. I understand that if I am approved for the Sliding Fee Program it is in effect for 12 months from the date of approval. I will promptly notify Insight and Empowerment if my financial status has changed.
5. If I need assistance after 12 months, I understand that I must re-apply for the Sliding Fee Program by submitting a new application.

Responsible Party Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

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	A	B	C	D	No Discount
	<u>0-100% of FPL</u>	<u>150%</u>	<u>250%</u>	<u>300%</u>	<u>Over 300% of FPL</u>
# of Family Members					
1	\$0 - \$15,960	\$23,940	\$39,900	\$47,880	\$47,880 +
2	\$21,640	\$32,460	\$54,100	\$64,920	\$64,920 +
3	\$27,320	\$40,980	\$68,300	\$81,960	\$81,960 +
4	\$33,000	\$49,500	\$82,500	\$99,000	\$99,000 +
5	\$38,680	\$58,020	\$96,700	\$116,040	\$116,040 +
6	\$44,360	\$66,540	\$110,900	\$133,080	\$133,080 +
7	\$50,040	\$75,060	\$125,100	\$150,120	\$150,120 +
8	\$55,720	\$83,580	\$139,300	\$167,160	\$167,160 +
Patient Payments	20% of Session	40% of Session	60% of Session	80% of Session	Full Pay