Document Title	Hill-Burton Uncompensated Services	**Version**	3
Approved By	Chief Finance Officer	**Approval Date**	05/27/2026
Reviewed By	*Policy Admin Group*, Patient Access, SMH Clinic	**Reviewed Date**	05/27/2026

PURPOSE:
To provide a determined amount of uncompensated services each year at Pioneer Medical Clinic (PMC) in Pierce, Idaho, as required by the Hill-Burton.

SCOPE:
Applies to Pioneer Medical Clinic Patients.

POLICY:
1. To publish in the county paper the notice of Hill-Burton uncompensated services available to PMC.
2. Signs providing notice are always posted and visible in the clinic waiting room.
3. Notices of availability are handed to each patient as they come into the clinic to be seen.
4. To qualify for uncompensated services patient (or parent, if patient is a minor) must fill out an application and submit it to the personnel at PMC.
5. Determination of Eligibility:
    a. Check to see that all data is complete and correct on application.
    b. Verification of income is complete
    c. Approval or Denial is done by PMC personnel at that time and explained to the patient the reason for the decision.
    d. Dates of approval, denial and applicant notification are written on the application at that time.
    e. All applications are signed by PMC personnel and put into a folder marked Hill-Burton. Application copies are also given to patient (or placed in patient chart), attached to the fee slip and sent to the billing department.

REFERENCES:

Link: Notice of availability of uncompensated services

INDIVIDUAL NOTICE

NOTICE OF AVAILABILITY OF UNCOMPENSATED SERVICES

PIONEER MEDICAL CLINIC (PMC) IN PIERCE, IDAHO IS REQUIRED BY LAW TO GIVE A REASONABLE AMOUNT OF ITS SERVICES WITHOUT CHARGE TO ELIGIBLE PERSONS WHO CANNOT AFFORD TO PAY FOR CARE. UNCOMPENSATED SERVICES ARE LIMITED TO SERVICES PROVIDED BY PMC.
TO BE ELIGIBLE TO RECEIVE UNCOMPENSATED SERVICES, YOUR FAMILY INCOME MUST BE AT OR BELOW THE FOLLOWING LEVELS.

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	(Nominal Fee $0)	(20% Pay)	(40% Pay)	(60% Pay)	(80% Pay)	(100% Pay)
1	$0–22,032	$27,540	$33,048	$38,556	$44,064	$44,065
2	$0–29,868	$37,335	$44,802	$52,269	$59,736	$59,737
3	$0–37,704	$47,130	$56,556	$65,982	$75,408	$75,409
4	$0–45,540	$56,925	$68,310	$79,695	$91,080	$91,081
5	$0–53,388	$66,735	$80,082	$93,429	$106,776	$106,777
6	$0–61,224	$76,530	$91,836	$107,142	$122,448	$122,449
7	$0–69,060	$86,325	$103,590	$120,855	$138,120	$138,121
8	$0–76,896	$96,120	$115,344	$134,568	$153,792	$153,793
For families/households with more than 8 persons, add $1183 for each additional person.						

IF YOU THINK YOU MAY BE ELIGIBLE FOR UNCOMPENSATED SERVICES, YOU MAY REQUEST THEM AT THE REGISTRATION DESK. PIONEER MEDICAL CLINIC WILL MAKE A WRITTEN, CONDITIONAL, OR FINAL DETERMINATION OF YOUR ELIGIBILITY FOR UNCOMPENSATED SERVICES AS FOLLOWS:

I. WITHIN TWO WORKING DAYS FOLLOWING A PRE-SERVICE REQUEST OR:
2. BY THE END OF THE FIRST FULL BILLING CYCLE FOLLOWING A POST-SERVICE REQUEST.

Link: Application for Hill Burton Assistance

St. Mary's Health

Clearwater Valley Health

Pioneer Medical Clinic

PO Box 340, Pierce Idaho 83546
208-476-8541

APPLICATION FOR HILL BURTON ASSISTANCE

Name: Last	First	M.I.
Address: Street	**City/State**	**Zip**

Social Security #	Home/cell phone	Employer

	Last 12 months	Last 3 months x 4	Family size
Patient's gross income			
Other family income			
Total family income			

Type of service rendered/requested: _____

Date(s) of service: _____

I certify the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my clinic charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the clinic the amount received for clinic charges. If any information I have given proves to be untrue, I understand the clinic may re-evaluate my financial status and take whatever action becomes appropriate.

Applicants signature: _____ Date: _____

Eligibility Determination (For office use ONLY)

Date application received: _____ Income verified ☐ yes ☐ no

Type of verification: _____

☐ The application is approved for care at no charge ☐ *Conditionally approved for care at no charge

☐ Or a reduction of _____% of allowable charges under Category B of the Poverty Income Guidelines.
Amount provided as uncompensated services is $_____.

*Condition(s): _____

☐ The applicant's request for free or reduced care services has been denied for the following reasons:

_____

Date of conditional determination: _____ Date of final determination: _____

Date applicant notified: _____ Approved by: _____

Clearwater Valley Health
301 Cedar
Orofino, ID 83544
208.476.4555 tel
smh-cvhc.org

St. Mary's Health
701 Lewiston Street
Cottonwood, ID 83522
208.962.3251 tel
smh-cvhc.org