Ilanka Community Health Center - Sliding Fee Discount Application

Kailangan mo ba ng tulong sa pagpunan ng form na ito?
Kung kailangan ng tulong maaring magtanong sa front desk.

Usted necesita ayuda para llenar las fomas?
Por favor pregunte a la recepcionista si necesita alguna asistencia para llenar las formas.

As a Community Health Center, we offer a sliding fee discount for services performed at our Clinic. Discounts are available based on income and family size regardless of insurance coverage.

One-Time Discount with Self-Verification: Patients may qualify for a discount on one visit using self-verification of income. Patient must fill out "Sliding Fee Discount Application" at time of initial visit.

Sliding Fee Discount Can be Extended for One Year: In order for the Sliding Fee Discount to be extended for a year, the patient has **7 Business Days** to provide verification of annual income and family size. Family size is determined by number of IRS recognized persons living in the same home and sharing expenses.

Sliding Fee Discount Schedules

Patients 100% or below Federal Poverty Guidelines (FPG) for Alaska are Eligible for Nominal Fee	Clinic Services	**$10.00 Nominal Fee**
	Behavioral Health Services	**$10.00 Nominal Fee**
	Ultrasound Services	**$30.00 Nominal Fee**
	In House Labs	**$0 Nominal Fee**
	In House Medications	**$0 Nominal Fee**
101 - 150%	Clinic, Behavioral Health and Ultrasound	**$50**
	In House Labs	**$5.00 each**
	In House Medications	**$2.00 each**
151 - 175%	Clinic, Behavioral Health and Ultrasound	**$75**
	In House Labs	**$10.00 each**
	In House Medications	**$4.00 each**
176 - 200%	Clinic, Behavioral Health and Ultrasound	**$100**
	In House Labs	**$15.00 each**
	In House Medications	**$6.00 each**
> 201%	No discounts available	

Federal Poverty Guidelines Annual Income Table

*For one-time self-verification, **please circle your income category**.*
Alaska PFD and income from children under the age of 18 is excluded.

Family/ Household Size	Nominal Fee < or =100%	$50 101%-150% FPG	$75 151%-175% FPG	$100 176%-200% FPG	No Discount >200%
1	$16,090	$16,091 - $24,135	$24,136 - $28,158	$28,159 - $32,180	$32,181
2	$21,770	$21,771 - $32,655	$32,656 - $38,098	$38,099 - $43,540	$43,541
3	$27,450	$27,451 - $41,175	$41,176 - $48,038	$48,039 - $54,900	$54,901
4	$33,130	$33,131 - $49,695	$49,696 - $57,978	$57,979 - $66,260	$66,261
5	$38,810	$38,811 - $58,215	$58,216 - $67,918	$67,919 - $77,620	$77,621
6	$44,490	$44,491 - $66,735	$66,736 - $77,858	$77,859 - $88,980	$88,981
7	$50,170	$50,171 - $75,255	$75,256 - $87,798	$87,799 - $100,340	$100,341
8	$55,850	$55,851 - $83,775	$83,776 - $97,738	$97,739 - $111,700	$111,701

For households with more than 8 persons add $5,680 for each additional person.

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In order to give you a discount on our services and comply with Federal Regulations, 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 once a year or more frequently, if requested.

Patient or Responsible Party Section

Full Name:_____ Date of Birth:____/____/____

Current Address:_____ City:_____ State/Zip: _____

Permanent Address:_____ City:_____ State/Zip: _____

Social Security Number:_____ Home Phone:_____ Work Phone: _____

Are you or any other household members covered by health insurance or Medicaid?____Yes____No

Please list all members and coverage information:

_____

_____

Please List All Members Living In The Household:

If eligible, all household members will be able to utilize the sliding fee scale discount.

Name; (First, middle initial, last name only if different)	Date of Birth	Relationship	Gender
	/ /		M / F
	/ /		M / F
	/ /		M / F
	/ /		M / F
	/ /		M / F
	/ /		M / F
	/ /		M / F
	/ /		M / F

For additional members please continue the list on a separate piece of paper.

FOR PATIENTS WITH MEDICAID COVERAGE:

Patients who are currently receiving Medicaid benefits are presumed to qualify for the $75 tier. Should you wish to qualify based on this criteria, you are not required to fill out the Income Portion of this application. Please skip to the last page to initial and sign the certification statement. A copy of your Medicaid card will be required for verification.

If you believe you are eligible to receive a larger discount due to family size and income, please fill out the remainder of this application, detailing all income sources.

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Disclosure and verification of ALL annual income is required.

The following are examples of acceptable forms of verification:

- Prior year federal tax return -front page showing gross adjusted income or schedule C on Form 1040
- Pay Stubs; last 2 pay stubs or if recently hired, verification letter of employment from the employer with expected wages noted.
- Social Security Letter of Acceptance
- Retirement benefits
- Unemployment Insurance documentation; letter of acceptance and amount or denial letter
- Letter of acceptance for public assistance (such as food stamps, Medicaid, Denali KidCare)
- Verification of special circumstances – must be in writing

List all household members who are currently employed or receiving Income:

Income includes, but is not limited to, wages, social security, unemployment benefits, retirement benefits and self-employment net income. (Exempt Income: Alaska PFD and income from children under the age of 18)

Name of person employed	Company name	Occupation	Gross Income (before deductions)	Seasonal
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N

If you have no income, how are you paying for housing, food, clothes and other essentials?

_____

_____

_____

_____

_____

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Certification Statement: <u>Please initial each line then sign and date below.</u>

_____I certify that the statements regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found to be inaccurate, I may be denied a discount and/or subject to legal action forknowingly providing false information.

_____By signing below, I agree that Ilanka Community Health Center may contact each employer of all persons working in the above-mentioned household and/or may contact various agencies to verify source of income.

_____I agree to notify Ilanka Community Health Center of all changes in income, address, living arrangements, number of household members, and/or other circumstances within **30 days** of a change.

_____I authorize all government agencies, employers, and any companies or agencies or person listed herein to provide information about me to the Ilanka Community Health Center. I also authorize ICHC to disclose this information to other healthcare providers as necessary to qualify me for affiliated discount programs.

_____I understand that the information given about me will be kept confidential except for the purposes noted above and will not be released without written permission. I also understand that if I do not agree with any decision made concerning this application, I can appeal the eligibility decision by following the "Patient Grievance Policy & Procedures ICHC-010".

Signature:_____Date: _____

Printed Name:_____

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DO NOT fill out this form, ICHC Office Use Only

Patient Name(s): _____

Patient Account #(s): _____

The above patient provided documentation of family size and income on this date:____/____/____

Documentation Provided:

Must provide one of the following for all household members 18 and older.

- ☐ Prior year federal tax return- front page showing gross adjusted income or schedule C on Form 1040
- ☐ Pay Stubs; last 2 pay stubs or if recently hired or verification letter of employment from the employer with expected wages
- ☐ Unemployment Insurance documentation; letter of acceptance and amount or denial letter
- ☐ Letter of acceptance for public assistance (such as food stamps, Medicaid, Denali KidCare)
- ☐ This patient is verified to be covered by Medicaid and is therefore eligible for the 60% discount
- ☐ Verification of special circumstances (such as no income or no reportable income)
  How is the patient meeting their financial obligations (this must be in writing)

Patient is eligible for the following discount:

- ☐ Not Eligible
- ☐ $100
- ☐ $75
- ☐ $50
- ☐ Nominal Fee

This information has been verified by:_____Date:_____

Approved by:_____Date:_____