Ilanka Community Health Center
Sliding Fee Discount Application
2016

Sliding fee discount is offered to our patients for services performed at ICHC.

One-Time Discount with Self-Verification:

We offer a one-time 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 **30 days** to provide verification of annual income and family size, This for all IRS recognized persons living in the household to determine eligibility for the Sliding Fee Discounts.

The Following are 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
- ☐ ___ 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

Sliding Fee Discount Schedules

100% or below FPL for Alaska Eligible for Nominal Fee	Clinic Services	$20.00 Nominal Fee
	In House Prescription Medications	$10.00 Each Nominal Fee
	In House Labs	$10.00 Each Nominal Fee
	In House Ultrasounds	$125.00 Each Nominal Fee
101 - 150%	Clinic Services	80% discount
	In House Prescription Medications	$10.00 each
	In House Labs	$10.00 each
	In House Ultrasounds	80% discount
151 - 175%	Clinic Services	60% discount
	In House Prescription Medications	$10.00 each
	In House Labs	$10.00 each
	In House Ultrasounds	60% discount
176 - 200%	Clinic Services	40% discount
	In House Prescription Medications	$10.00 each
	In House Labs	$10.00 each
	In House Ultrasounds	40% Discount
> 201%	No discounts available	

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Federal Poverty Guidelines Annual Income Table

Do you fit into one of these categories? If so, you may qualify for a sliding fee discount

Family/ Household Size	Nominal Fee <100%	80% Discount 101%-150% FPL	60% Discount 151%-175% FPL	40% Discount 176%-200% FPL	No Discount >201%
1	$14,840	$14,841 - $22,260	$22,261 - $25,970	$25,971 - $29,680	$29,681
2	$20,020	$20,021 - $30,030	$30,031 - $35,035	$35,036 - $40,040	$40,041
3	$25,200	$25,201 - $37,800	$37,801 - $44,100	$44,101 - $50,400	$50,401
4	$30,380	$30,381 - $45,570	$45,571 - $53,165	$53,166 - $60,760	$60,761
5	$35,560	$35,561 - $53,340	$53,341 - $62,230	$62,231 - $71,120	$71,121
6	$40,740	$40,741 - $61,110	$61,111 - $71,295	$71,296 - $81,480	$81,481
7	$45,920	$45,921 - $68,880	$68,881 - $80,360	$80,361 - $91,840	$91,841
8	$51,120	$51,121 - $76,680	$76,861 - $89,460	$89,461 - $102,240	$102,241

For family households with more than 8 persons add $5,200 for each additional person

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	Social Security Number
	/ /		M / F	
	/ /		M / F	
	/ /		M / F	
	/ /		M / F	
	/ /		M / F	
	/ /		M / F	

For additional members please continue the list on the top of the next page.

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Please list all household members who are currently employed:

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

If you have no income, how are you meeting your financial obligations?

_____

_____

NOTE: To comply with federal regulations, in order to give you a discount on our 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 once a year.

Certification Statement:

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 for knowingly 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: _____

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Patient DO NOT fill out this form, ICHC Office Use Only

Verification of Information for Sliding Scale Discount

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 over age of 18.

- ☐ 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
- ☐ 80% Discount
- ☐ 60% Discount
- ☐ 40% Discount
- ☐ Nominal Fee

This information has been verified by: _____ Date:_____

Approved by: _____ Date:_____