ILIULIUK FAMILY AND HEALTH SERVICES, INC. COMMUNITY HEALTH CENTER

Discount Schedule Eligibility Information

ELIGIBILITY FOR THIS PROGRAM IS BASED ON FINANCIAL NEED

**Why does Iliuliuk Family and Health Services need to know your household income?**

Some of our program budget comes from grant money. For most of these grants, income information from all of our patients is necessary to prove financial need in the communities we serve. The grant monies allow us to provide a higher level of quality and more services than we could without them. In order to get and keep these grants, we need to provide income information to prove that we are serving the people the grant money has been set aside for.

**ALL INFORMATION IS CONFIDENTIAL**

**Definition of Household:**

All members of a household who are related and pooling financial resources are counted as one family if the arrangements are considered permanent and support greater than room and board is provided. Unrelated members of a household who are supporting one another financially are considered one family.

**Definition of Income:**

Income is defined as total cash before taxes from all sources, which can include:

* Wages and Salaries
* Receipts from self-employment after deductions for normal operating expenses
* Regular payments through public assistance, social security, longevity, unemployment, strike benefits, military allotments, disability, rental income, regular support from an absent family member or someone not living in the household (includes child support), government or private pensions, and regular insurance or annuity payments
* Income from dividends (including permanent fund), interest, rent royalties, or income from estates or trusts
* Savings accounts (average balance of past 6 month’s activity, divided by 6 months’ equal monthly portion of income).

**How do I qualify?**

All applicants are asked to provide proof of household income and family size to qualify for discounted fees. There is a 30 day grace period from the date of your visit to the time the application needs to be returned. If the application is not returned within 30 days, you will be responsible for 100% of charges. If the application is returned within 30 days and the patient qualifies on the scale, adjustments will be made starting with the date of the application was provided to the patient. Information will be updated at least once every year, or anytime your income, household size and/or medical insurance status changes. It is your responsibility to keep an up to date sliding scale application with IFHS.

**Discount Schedule Eligibility Worksheet**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last, First, MI

You must provide proof of income to qualify for the discount schedule. This information must be updated at least annually, and any time your household income size and/ or medical insurance status changes. You will be responsible for the full amount of the visit and the discount will not be applied to your account until you give IFHS the required proof of income. If proof of income is given to us within 30 days of the visit, and if you are eligible, the discount will be applied retroactively and all following visits will be discounted. Proof of income includes: prior year completed income tax forms , pay stubs from the last three months, unemployment or other benefits income receipts, and/or letters of income verification from two other individuals or from the employer(s). List your name and the names of ALL individuals who lives with you. Name, Relationship, Age, Gender, Date of Birth, Annual Income, Employer, SELF. If you need more space, please continue on the back of this form.

**(List your name and the names of ALL individuals who lives with you)**

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| --- | --- | --- | --- | --- | --- | --- |
| Name | Relationship | Age | Gender | Date of Birth | Annual Income | Employer |
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* Are you currently employed? \_\_\_Yes \_\_\_No
* Do you work seasonally only? \_\_\_Yes \_\_\_No
* How much money do you and all who live in your household bring in per
* Week $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Month $\_\_\_\_\_\_\_\_\_\_\_\_\_ Year $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* If you are not working, how are you meeting your monthly expenses? Please check below

Savings \_\_\_\_\_ Borrowing \_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

* Do you have health insurance? \_\_\_Yes \_\_\_\_\_ No, If yes, what is the deductible amount? $ \_\_\_\_\_
* Do you have Medicaid? \_\_\_\_\_Yes \_\_\_\_\_No, Did you apply? \_\_\_\_Yes \_\_\_\_No, Were you denied? \_\_\_\_Yes \_\_\_\_\_ No
* Do you have Medicare? \_\_\_\_\_ Yes \_\_\_\_\_\_No, Are you eligible to apply? \_\_\_\_Yes \_\_\_\_\_No

List **ALL** that you, and those living in your household receive:

(Amount per month/year Salary or wages)

$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unemployment

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pension/Retirement

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Rental Income/Dividends

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Interest

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spousal Support

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Child Support

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Foster Care

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Public Assistance (ATAP)

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Permanent Fund

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Longevity Bonus

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Self-Employed (Net Amount)

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Worker’s Comp Benefits

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Disability Benefits

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Total Monthly/Annual Household Income

**PLEASE READ AND SIGN**

I authorize all government agencies, employers and any companies, agencies, or persons listed herein to provide information about me to Iliuliuk Family and Health Services, Inc. Community Health Center (IFHS), the State of Alaska, and/or the federal government. I also authorize IFHS to disclose this information to agencies, third party payers and other health care providers as necessary to qualify me for reduced fees. 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. I agree to notify IFHS of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential except for the purposes noted above and not be release without my written permission. I also understand that if I do not agree with any decision made concerning this application, I have the right to ask in writing for a review by the CEO.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for your cooperation!**

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| **FOR OFFICE USE ONLY**  Total Annual Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Family Members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Verified By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Verified with: Pay Stubs \_\_\_\_ Tax Forms \_\_\_\_\_ EVF \_\_\_\_\_\_ CVF \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_  Proof Returned Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Discount Effective Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Qualified? Yes \_\_\_\_\_ No \_\_\_\_\_\_\_ Discount %: 100%, 75%, 50%, 25%  Requalify Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |