**ILIULIUK FAMILY AND HEALTH SERVICES, INC. COMMUNITY HEALTH CENTER**

Sliding Scale Fee Discount Program Application

ELIGIBILITY FOR THIS PROGRAM IS BASED ON FINANCIAL NEED

IFHS Sliding Scale Fee Discount Program reduces the cost of health care for eligible patients. Your eligibility for this program and the amount of your discount are based on:

• Household size

• Annual income

All patients are encouraged to apply, even if you have health insurance, including Medicare and Medicaid. Medicare/ Medicaid does not pay for all services. If you have insurance and are eligible for the sliding scale fee discount, your discount will apply to charges that your insurance does not pay. If you do not have insurance and are eligible for the sliding scale fee discount, your discount will apply to all the costs of care you receive at IFHS.

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

Our Sliding Scale Fee Discount Program budget comes from grants awarded to Community Health Centers. Your household income information is necessary to prove the financial need in the community we serve. This grant funding allows us to provide a higher level of quality care and more services for our community. In order to keep these grants, we are required to provide income information to prove that we are providing quality services to our patients with financial need. The sliding scale fee discount applies to all services provided directly by IFHS, including prescription medications from IFHS’ dispensary.

**ALL INFORMATION IS CONFIDENTIAL**

**Definition of Household:**

A household includes everyone who shares resources and depends on the same income, unless it is on a temporary basis. Your household members may or may not be related to you. They may or may not live with you. These arrangements are considered one household:

• Both related and unrelated individuals who share resources and depend on the same income.

• Both married and unmarried individuals who share resources and depend on the same income.

• An adult child (19 years old and older) who is claimed as a dependent on a parent or guardian’s tax return, even if they do not share resources or depend on the same income.

**Definition of Income:**

Income is defined as total cash after 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 the application was provided to the patient. Information will be updated 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.

**Forms Required**

1. If employed, you must provide one of the following;

- Employment Verification Form – completed by employer

- Recent tax return OR 3 month’s paystubs

1. If Unemployed, you must provide the following;

* Two Circumstances Verification Forms (CVF)

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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 annually, and at 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 provide IFHS the required proof of income and eligibility has been determined. If proof of income is provided within 30 days of the visit, and if you are eligible, the discount will be applied retroactively, and all following visits will be discounted for the next 12 months. Proof of income includes, prior year completed income tax statement, 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 live with you. If you need more space, please continue on the back of this form.**(List your name and the names of ALL individuals who live with you)**

*\*All “individuals” who are employed will need to provide income information\**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | Relationship | Age | Gender | Date of Birth | Annual Net Income | Employer |
|  | **SELF** |  |  |  |  |  |
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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 (complete one)

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 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 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 that could affect my eligibility. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



FOR OFFICIAL USE ONLY

tOTAL aNNUAL iNCOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

nUMBER OF fAMILY mEMBERS: \_\_\_\_\_\_\_\_\_\_\_

vERIFIED bY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

vERIFIED WITH: ( ) pAY sTATEMENT(S) ( ) tAX rETURN ( ) oTHER

pROOF RETURNED dATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **qualified? ( ) yes ( ) nO**

dISCOUNT eFFECTIVE dATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ dISCOUNT eXPIRE dATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**dISCOUNT %: ( ) 100% ( ) 75% ( ) 50% ( ) 25%**

**ILIULIUK FAMILY AND HEALTH SERVICES, INC.**

**Residence and/or Financial Support Statement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that

(Name of person providing residence and/or financial support)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of applicant)

**Check all that apply and complete appropriate response:**

lives with me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(address)\_

receives $\_\_\_\_\_\_\_\_\_\_\_\_ per month from me as a regular contribution to her/his income.

is supported by me in that I pay for his/her expenses (room and board).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of person providing residence and/or financial support) (Date)