ILIULIUK FAMILY AND HEALTH SERVICES, INC. COMMUNITY HEALTH CENTER

Sliding Fee Discount Program Application Information

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 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 fee discount, your discount will apply to all the costs of care you receive at IFHS. Your sliding fee discount is only valid for one year.

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 includes but not limited to:

- 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 (including child support), government or private pensions, and regular insurance or annuity payments.
- Income from dividends (including Alaska permanent fund dividend, PFD), interest, rent royalties, or income from estates or trust fund.
- Savings accounts (average balance of past 6 months' activity, divided by 6 months' equal monthly portion of income)

How do I qualify?

- All applicants must provide **proof of household income and family size** to determine eligibility for discounted fees.
- You have a 30 day grace period from the date the application is given to you to complete and return it for review.
- If the application is **not returned within 30 days,** you will be responsible for 100% of the charges.
- If the application **is returned within 30 days** and you qualify, any eligible adjustments will be applied **retroactively to the date the application was provided.**
- Your sliding fee information must be **updated once a year**.
- You **must inform us if there are changes** to your household income, household size, or changes to your insurance status at any time these changes occur.
- It is **your responsibility to keep an up-to-date sliding fee discount 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 1 month's paystubs / pay statement
2. If Unemployed, you must provide the following:
   - Two Circumstances Verification Forms (CVF)
   - Residence/ Financial Support Statement

NOTE:

If you provide false information, you will not be eligible for the Sliding Fee Discount Program.

This Sliding Fee Discount Application is subject to independent verification by IFHS Financial Counselor, which may result in a determination that is different than the one provided on the current date.

ILIULIUK FAMILY AND HEALTH SERVICES, INC

Sliding Fee Discount Program Application

Name: _____ Date of Birt _____ 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 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					

- 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 _____ _____
- 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? _____ _____

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 _____ _____

FOR OFFICIAL USE ONLY

TOTAL ANNUAL INCOME: __

NUMBER OF FAMILY MEMBERS: _

VERIFIED _____ 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, _____y 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 _____

☐ receives $___ _____nth 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)