SUNSHINE COMMUNITY HEALTH CENTER

HC 89 BX 8190Talkeetna, AK 99676 (907)733-2273 fax (907) 733-1735 PO Box 1049 Willow,AK 99688 fax (907)495-4106

Discount Fee Eligibility Application

GENERAL INFORMATION: Eligibility for this program is based on income. To apply, you must provide proof of income prior to your appointment time or within **48 hours** of a visit. You will be responsible for the full amount of your charges if proof of income is not received during that time frame. Proof of income is required at least annually or any time there is a change in income and household size.

PLEASE PROVIDE THE FOLLOWING:
- Photo ID
- Current utility statement or mail with current address
- Medicaid and/or DKC Approval or Denial Letter (Children under 18 are required to apply for DKC in order to be considered under this SFS application). Please indicate below if you are a recipient of Alaska House Assistance and if you are VA Eligible.

Please submit one of the following forms of income verification:
Current tax return, 3 pay stubs, Declaration of No Income form, Disability/SS award letter, Unemploment determination letter
We DO NOT accept bank statements or tax returns more than 2 years old if you are self employed

Marital Status: Married ❑ Single ❑ Single w/ children❑ Widowed ❑

Applicant: _____ (Last) _____ (First) ____ (M) **Date of Birth:** _____

Co-applicant: _____ (Last) _____ (First) ____ (M) **Date of Birth:** _____

Dependent: _____ (Last) _____ (First) ____ (M) **Date of Birth:** _____

Dependent: _____ (Last) _____ (First) ____ (M) **Date of Birth:** _____

Dependent: _____ (Last) _____ (First) ____ (M) **Date of Birth:** _____

Other sources of healthcare coverage:
Medicare ❑ Medicaid ❑ Insurance ❑ Other ❑ _____ None ❑

Recipient of Alaska Housing Assistance? ❑ Yes ❑ No VA Eligible? ❑ Yes ❑ No

Income: Wages/Salary and other income including, interest, dividends, rental, alimony, child support, SS disability, AK Permanent fund, Social Security, Unemployment Compensation, and business income.

Monthly _____ Annual _____

I authorize all government agencies, employers, and any companies or agencies or persons listed herein to provide information about me to the Sunshine Community Health Center, the State of Alaska, and or the federal government. I also authorize this clinic to disclose this information to agencies, third party payers and other health care providers as necessary to qualify me for reduced fees. 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 the clinic 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 released 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 Executive Director.

I understand that I will be responsible for the full cost of my visit if my proof of income is not received within 48 hours.

Applicant Signature: _____ **Date:** _____

For Office Use Only

The following paper work for slide eligibility has been reviewed & verified and is on file:

_____Proof of income ___Tax return ____ Letter from Employer ____other income verification (list on back)

____ Patient declined ___ Patient Not Eligible **Effective dates of coverage** _____ **to** _____

Qualifies at: ___ NF / A ___80%/B ___60%/C ___40%/D ___20%/E ___Full Pay/F

SLIDING FEE INCOME WORKSHEET

To be completed by staff

PATIENT NAME		HOUSEHOLD SIZE	
		Weekly x 52 Bi-Weekly x 26 Bi-Monthly x 24 Monthly x 12	
INCOME	**AMOUNT**	**PERIOD**	**ANNUAL**
Gross Wages/Salary			$
OTHER INCOME			
Rental			$
Alimony			$
Child Support			$
SS Disability Benefits			$
Alaska Permanent Fund			$
Social Security			$
Unemployment Compensation			$
Adult Public Assistance			$
Interest/Dividends			$
OTHER INCOME LISTED BELOW			
			$
			$
			$
TOTALS			**$**
COPIES ATTACHED	Check if reviewed and attached		
Pay Stubs/Wages			
Tax return			
Unemployment			

Staff _____

Date _____