SUNSHINE COMMUNITY HEALTH CENTER

Talkeetna: HC 89 Box 8190 Talkeetna, AK 99676 phone (907) 733-2273 fax (907) 733-1735. Willow: PO Box 1049 Willow, AK 99688
phone (907) 495-4100 fax (907) 733-1735

Discount Fee Eligibility Application

GENERAL INFORMATION: Eligibility for this program is based on income. To apply, please provide proof of income prior to your appointment time or as soon as possible following your visit. You will be responsible for the full amount of your charges if proof of income is not received. Proof of income is required at least annually or any time there is a change in income and household size. ALL members of the household MUST be listed on this application.

Please submit current ID and one of the following forms of income verification:

Current tax return, W2 and most recent three pay stubs, Declaration of No Income form, Disability/Social Security award letter, unemployment determination letter. We **DO NOT** accept tax returns more than two 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 ❑

PFD: ❑ Yes ❑ No **VA Eligible:** ❑ Yes ❑ No

Income: Income includes, but is not limited to: Wages, Self-Employment net income, Social Security, Retirement/Pensions, Unemployment, Rental Income, all dividends (Stocks & Bonds and Interest) including Alaska Permanent Fund Dividend or Tribal Dividends, Child Support, Spousal Support, Foster Care, Public Assistance, Longevity Bonus, Worker's Comp Benefits, Disability Benefits, Veterans Benfits, etc.

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.

Applicant Signature: _____ **Date:** _____

For Office Use Only

The following paperwork 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** _____

___A: $25 ___B: 80% ___C: 60% ___D: 40% ___E: 20% ___F: Full Pay

*Fees for Medical and BH Appointments

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 / Statement Letter			
1099			
Social Security Statement Letter			

Staff _____

Date _____