KODIAK COMMUNITY HEALTH CENTER

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SLIDING FEE DISCOUNT PROGRAM

Kung kailangan mo ng tulong sa translation magyaring hilingin sa front desk.
Si necesita ayuda con la traducción, por favor pedir a la recepción.

What is the Sliding Fee Discount Program?

The Sliding Fee Discount Program (SFDP) is a program designed to provide free or discounted care to Kodiak Community Health Center (KCHC) patients who have no means, or limited means to pay for their medical services. **At KCHC no patient will be denied health care services due to an inability to pay.**

According to federal regulation, two pieces of information are required, in order to be considered for this program:

1. The household income
2. The number of people who live in the household

In order to be approved for the SFDP, you must provide **accurate and comprehensive proof of income** and **list all persons within your household within 10 business days** of the date you receive an application. Failure to return a completed application by the due date will result in denial of the SFDP application. **Incomplete applications will result in 100% patient responsibility for all charges.** In addition, once approved, you must report any changes in household income or number of members of the household when these charges occur. **Each application approved is in effect for 1 year. A new application must be submitted annually to be considered for continued eligibility.**

Once approved for the SFDP, patients are responsible for any balance not covered under the SFDP agreement. Patients are financially responsible should the account be referred to a collection agency and shall pay all delinquent accounts including accrued interest and fees.

Falsification of information submitted will result in forfeiture of all Sliding Fee Discount Program privileges.

Eligibility for the Sliding Fee Discount Program

All patients are eligible to apply for the sliding fee discount program regardless of insurance status. Discount eligibility is determined based upon household income and household size in accordance with the current Federal Poverty Income Level Guidelines. The discount fee ranges from $3, $25, $50, or $75 for an uninsured patient. Or in the case of an insured patient, the patient responsibility portion is the co-pay/co-insurance or designated fee, whichever is less.

INCOME DEFINITION AND PROOF REQUIRED

1. Income Definition

Income is based on the gross income of all household members and is used to determine whether the applicant meets a specific Federal Poverty Income Level. The following are examples of the types of income to be reported: salary, wages, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trust, alimony, Alaska Permanent Fund Dividend, assistance from friends or family members, and other miscellaneous sources.

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3. Acceptable forms of proof for determining income include the following:

Required: Documentation of all income within the last 30 days **OR** your most recent Federal Income Tax Return (Form 1040) if you do not have a federal Income Tax Return on file then submit all recent tax documents (1099, W-2's etc).

Examples of monthly income are as follows:

1. Pay check stubs: (Within last 30 days.)
2. Agency Letter: Letter from the Social Security Administration, Medicaid, Adult Public Assistance, Social Service Agency, or Veterans Administration stating income level if received within the past year.
3. Unemployment Verification: Paperwork proving unemployment status and the amount of unemployment compensation being received.
4. Court documents Child Support/Alimony/Foster Care Payments: Official documents stating child support and/or alimony amount as awarded by a judge.
5. Permanent Fund Dividend.
6. Official Paperwork: Paperwork documenting retirement, disability, SSI and/or SSA benefits.
7. Employer Letter: For those who do not have a recent pay check stub, a letter from the employer detailing current gross income and frequency of pay periods may be accepted. Contact information must be provided so that information can be verified.
8. If you are Unemployed, and/or do not have any source of verifiable income, please document explanation on the Self Declaration of Income Form (page 4).

HOUSEHOLD SIZE DEFINED

Household members include but are not limited to the following definitions:

1. All members of a household who are related and/or pooling resources are counted as one household. (I.e. adult children living in the home but filing taxes separately).
2. Unrelated members of a household who are supporting one another financially or share resources are considered one household (i.e. living as married/cohabitation).
3. Family members living in the same household on a ***temporary*** basis due to a hardship that are receiving room and board are considered a separate household.
4. Members of a household who are unrelated and do not share income are considered separate households.

WHAT IS NOT COVERED:

The KCHC SFDP does NOT COVER outside services (those not provided by KCHC) such as; **lab services with Quest Diagnostics, services rendered at Providence Kodiak Island Medical Center** (both Quest and PKIMC have their own discount programs available). The SFDP is good for 1 year from the effective date, a new application must be submitted each year for continued discounts to be determined.

The Sliding Fee Discount Program Application is subject to independent verification by the KCHC Staff. ***Failure to return a completed application by the due date may result in denial of the current SFDP application.*** *Applicants may re-apply for the SFDP at any time. Application deadline extensions may be approved on a case by case basis. Exceptions may be approved by the Executive Director.*

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SLIDING FEE DISCOUNT PROGRAM APPLICATION

Applicant Information		
Name: (AS APPEARS ON PHOTO ID/INSURANCE CARD)		Date of Birth: (MM/DD/YYYY)
Home Address:		
Mailing Address:		
Home Phone:	Work Phone:	Cell Phone:

FOR OFFICE USE ONLY	
Date Mailed:	KCHC Staff Initials
Date Given:	
Date Due:	
Date Accepted:	

Household Member Name (First, Last) Please provide copy of photo I.D. (If additional space is needed please list on separate page and attach.)	Relationship to Applicant (e.g. Self, Spouse, Child, Relative, Friend)	Birth Date (MM/DD/YYYY)	Employment Status Full/ Part/ Unemployed/ Retired	CHECK APPROPRIATE BOX "X" AND ATTACH SUPPORTING DOCUMENTS: Income in last 30 days	Description

VA Eligible? ☐ Yes [Medical ☐ Dental ☐] ☐ No

Email Address: _____

Examples of Income: Please check all types received in the past 30 days and attach documentation to this application

- ☐ Pay Stubs for 1 month
- ☐ Unemployment Benefit Letter
- ☐ Adult Public Assistance Benefit Letter
- ☐ Retirement Statements
- ☐ Social Security/Disability/SSI Benefit Letter
- ☐ Forster Care Payments
- ☐ Permanent Fund Dividend
- ☐ Child Support/Alimony
- ☐ Workman's Compensation
- ☐ Letter from Employer w/average weekly hours and rate of pay
- ☐ Rental Income
- ☐ Other: _____

If you are unable to provide documentation of income the attached Self Declaration of Income form must be completed and returned with this application.

I agree with the above, whether I sign as a patient or the guarantor or another, that I am responsible for the account balance in accordance with the regular rates and terms of KCHC. I declare the information provided on this application along with supporting documentation is true and correct to the best of my belief and knowledge. Furthermore, I understand that it is my responsibility to inform KCHC of any changes to my income that may change my eligibility for sliding fee discounts.

I also understand that should KCHC become aware that any of this information has been falsified to fraudulently receive services that my participation will be revoked and I will be responsible for 100% of the usual and customary charges of KCHC.

_____ _____

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Signature of Applicant Date

COMPLETED APPLICATION MUST BE RETURNED ON OR BEFORE THE DUE DATE LISTED ABOVE TO BE CONSIDERED FOR APPROVAL

Sliding Fee Discount Program
Self- Declaration of Income

Complete the information below **only** if you have no other way to document your income. All of the appropriate boxes below must be checked and all questions answered. Failure to complete this form may result in denial of your Sliding Fee Discount Program application.

- ☐ I get paid in cash.
- ☐ I am self-employed but do not file taxes.
- ☐ I do not get pay checks and/or stubs.
- ☐ I have not had any income in the last 30 (thirty) days.
- ☐ I did not have any income in the last calendar year.
- ☐ I cannot get a letter from my employer.

My income in the last 30 (thirty) days was: _____

My income in the last calendar year was: _____

Applicants/Recipients must read the following and sign below:

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for Kodiak Community Health Centers sliding fee discount program. I understand that KCHC staff may verify the information on this form. I also understand that should KCHC become aware that any of this information has been falsified to fraudulently receive services that my participation will be revoked, I may have to repay benefits received, and I will be responsible for 100% of the usual and customary charges of KCHC.

Name: _____ Signature: _____Date: _____

For Translators Only- Read the following and sign below:

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me. I did not modify the information in any way.

Name: _____ Signature: _____Date: _____