

GIRDWOOD HEALTH CLINIC

Sliding Fee Discount Application

GHC ADMIN USE ONLY	
Application Outcome:	<input type="checkbox"/> Discount Category <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> Not Eligible
Effective Date:	Expiration Date:
GHC Rep Signature	

Patient Name:	Application Date:
Patient ID #:	Documentation Due Date:

- Girdwood Health Clinic's Sliding Fee Discount Program (SFDP) is based solely on family size and total household income in relation to the current Federal Poverty Guidelines.
- To be considered for this program you need to complete the following application and submit proof of income.
- If you do not supply adequate proof of income or you do not qualify based on the proof of income received, you will be responsible for payment all patient responsibility amounts due.
- The discount will be applied to services at Girdwood Health Clinic starting on the effective date listed above. Once you have qualified for the program you will be eligible for twelve (12) months from date of qualification.

1- Applicant Information

Name of Responsible Party:	Date of Birth
Home Phone	Cell Phone
Address	Email Address
City, State, Zip	

2- Household Members

Name (Last, First)	Relationship	Date of Birth	Monthly Income	Employer / Self-Employment
	SELF		\$	
			\$	
			\$	
			\$	
			\$	

Does anyone in the household receive additional income? Yes No

If yes, please list the amount received and identify if amounts are per month or per year:

Retirement/Pension	\$	mo / yr	Unemployment	\$	mo / yr
Social Security	\$	mo / yr	Disability	\$	mo / yr
VA	\$	mo / yr	Workers Comp	\$	mo / yr
AK Senior Benefit	\$	mo / yr	Alimony	\$	mo / yr
Permanent Fund Dividend (PFD)	Do not include		Rental Income	\$	mo / yr
Other	\$	mo / yr	Describe "Other"		

If you are not working, how do you meet your living expenses? Savings Borrowing Other: _____

Proof of income Documentation is required for this program. Please select the documents you intend to submit. Federal Tax Return Pay Stubs for the Past Month Proof of Other Income

Do you currently have medical insurance;

- Private Insurance: Blue Cross, Premera, Cigna, Aetna, etc : _____ Yes No
- Public Insurance: Medicare, Medicaid, Denali KidCare: _____ Yes No

*** The Girdwood Health Clinic offers free assistance with Health Insurance Enrollment**

Would you like to meet with our Certified Application Counselor to determine your eligibility for Medicaid, Medicare or Affordable Care Act low-cost health Insurance? Yes No

3 – Patient Attestations

Initial	Please initial next to each statement below to confirm that you have read and understand
	I understand that I must provide proof of income within 10 business days of submitting my application, and that discounts will not be applied until my application has been approved. Incomplete applications cannot be processed.
	I understand that approved eligibility determination will be valid for 12 months , and that I must reapply at the end of the 12-month period.
	I will notify Girdwood Health Clinic as soon as possible and submit an updated application if my financial circumstances change.
	I understand that it is my responsibility to know the status, effective date and ending date of my discount eligibility, and that I can call the clinic to ask for detailed information.
	I understand that I may receive bills for services from outside providers associated with my visit including Laboratory testing, X-ray interpretation by Radiologists, and Orthopedic braces, crutches or splints.
	I understand that I am responsible for payment of discounted amounts due at the time of service unless payment arrangements have been made with clinic staff.

4 – Signature

I certify that the **information provided is true and accurate** to the best of my knowledge and that submission of false information will automatically disqualify from this program.

Signature

Today's Date

For Office Use Only:	
# Individuals in the Household: _____ Documents Provided: <input type="checkbox"/> Federal Tax Return Year _____ <input type="checkbox"/> Pay Stubs x _____ <input type="checkbox"/> Other Proof of Income _____ _____ _____	Annual Household Income: \$ _____ Total Annual Income Calculations: \$ _____ Annual income per tax return ~~OR~~ \$ _____ income document #1 \$ _____ income document #1 \$ _____ TOTAL _____ divide by # weeks in income x 52 weeks = _____ Estimated Annual Income
Patient Notified: Y/N Date Notified: _____ In Person _____ Letter _____	<input type="checkbox"/> Eligible Discount: A B C D <input type="checkbox"/> Not Eligible