Ilanka Community Health Center - Sliding Fee Discount Application

Kailangan mo ba ng tulong sa pagpunan ng form na ito?
Kung kailangan ng tulong maaring magtanong sa front desk.

Usted necesita ayuda para llenar las fomas?
Por favor pregunte a la recepcionista si necesita alguna asistencia para llenar las formas.

As a Community Health Center, we offer a sliding fee discount for services performed at our Clinic. Discounts are available based on income and family size regardless of insurance coverage.

Patient or Responsible Party Section

Full Name:_____Date of Birth:_____/_____/_____

Mailing Address:_____City:_____State/Zip: _____

Permanent Address:_____City:_____State/Zip: _____

Social Security Number:_____Home Phone:_____Work Phone: _____

Do you have Medicaid? ____Yes ____No

If you have Medicaid, it auto qualifies you for Tier 3 and providing proof of income is not required. However, patients are encouraged to provide income verification to see if they qualify for a greater discount.

Please list all insurance or other coverage information: _____

_____

Household Members & Income:

***Household* is defined as any IRS recognized individual residing in the same home and sharing resources. This may include yourself, spouse, children and any other IRS recognized dependent.**

Disclosure and verification of ALL annual income is required. **Income includes, but is not limited to, wages, social security, unemployment benefits, retirement benefits and self-employment net income. (Exempt Income: Alaska PFD and income from children under the age of 18) See reference sheet provided.**

Full Name:	Date of Birth	Relationship	IRS Dependent?	Employer	Adjusted Gross Income
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	/ /				
	/ /				
	/ /				
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For additional members please continue the list on a separate piece of paper.

If you have no income, how are you paying for housing, food, clothes, and other essentials?

_____

_____

Discount Table

Category	Nominal Fee	Tier 1	Tier 2	Tier 3	>200
Clinical Services	$10	$50	$75	$100	No discount, regular charges apply based on type of visit.
Behavioral Health	$10	$50	$75	$100	
Eye Exams*	$10	$50	$75	$100	
Teeth Cleanings**	$10	$50	$75	$100	
Ultrasound	$30	$50	$75	$100	
In House Labs	$0	$5	$10	$15	
In House Medications	$0	$2	$4	$6	

* Discounts apply toward Eye Exams for glasses. Contact lens exams, eyeglasses, contact lens, or other supplies are not covered.
** Discounts apply towards Teeth Cleaning services. Additional services or supplies are not covered.

One Time Discount with Income Estimate:

Your first visit is eligible for discounts based on the information provided on the "Household Members & Income" section. **For this application to be complete,** all proof of income has to be returned to Ilanka Clinic within **7 Business Days**.
You will receive written notification of eligibility after application has been fully processed.

Certification Statement

I certify that the information I provided is 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 that ICHC may contact each employer of all persons I have listed as living in my household to verify income.

I agree to notify ICHC of all changes in income, address, living arrangements, number of household members, and/or other circumstances within **30 days** of a change.

I authorize all government agencies, employers, and any companies or agencies or person listed herein to provide information about me to ICHC. I also authorize ICHC to disclose this information to other healthcare providers as necessary to qualify me for affiliated discount programs.

I understand that the information given about me will be kept confidential except for the purpose noted above and will not be released without written permission. I also understand that if I do not agree with any decision made concerning this application, I can appeal the decision in writing.

Signature: _____ Date: _____

Printed Name: _____