Girdwood Health Clinic
Sliding Fee Discount Program

The Girdwood Health Clinic does not want financial constraint to prevent individuals and families from seeking needed health care, therefore we have adopted a sliding fee discount program. Patients who are underinsured as well as uninsured can meet with our Eligibility Specialist to determine their eligibility.

WHAT YOU NEED TO APPLY:

Personal Identification:

- Photo ID
- Social Security Number *optional
- Green Cards for Permanent Residents
- Certificates for Naturalized Citizens

Current Income:

- Pay Stubs for the past month
- Agency Letter: Social Security Administration, Veterans Administration, Medicaid or Social Service Agency (i.e. AFDC, Food Stamps, or WIC) etc.
- Unemployment Verification: proof of unemployment compensation
- Court Documents: Documents citing alimony as awarded by a judge
- Official Paperwork: Retirement, Pensions, Disability, SS Benefits
- Employer Letter: Letter from employer detailing gross income and frequency of pay periods
- Income Tax Return: Signed copy of the most recent tax return showing Adjusted Gross Income and supporting schedules for business income
- If you are SELF – EMPLOYED include the previous year's income tax return.

* Types of income include salary, wages, unemployment, senior benefits, pensions or retirement income, dividends, AK Permanent Fund, income from estates, veterans' payments, trust and other sources.

HOUSEHOLD CRITERIA

All members of a household who are related and/or pooling resources are counted as one family/household (including adult children living in the home and filing separate taxes). Unrelated members of a household who are supporting one another financially or share resources are considered one household (living as married/cohabitation).

SEPARATE HOUSEHOLD CRITERIA

Family members living in the same household on a temporary basis due to a hardship and receive room and board are separate households. Members of a household who are unrelated and do not share income are separate households.

Please submit completed applications to the Girdwood Health Clinic.
Questions? Call 907-783-1355 for assistance from our Eligibility Specialist.

2020 Annual Income Eligibility Guidelines Effective January 24, 2020					
Household Size	**A**	**B**	**C**	**D**	
	100%	**101-150%**	**151-175%**	**176-200%**	**>200%**
1	$15,950	$23,925	$27,913	$31,900	No discount, charges depend on type of visit
2	21,550	33,325	37,713	43,100	
3	27,150	40,725	47,513	54,300	
4	32,750	49,125	57,313	65,500	
5	38,350	57,525	67,113	76,700	
6	43,950	65,925	76,913	87,900	
7	49,550	74,325	86,713	99,100	
8	55,150	82,725	96,513	110,300	
For households w/more than 8, add $ 5,600 for each add'l person	5,600	8,400	9,800	11,200	

Sliding Fee Discounts *(applies only to in-house services)*					
Category	Federal Poverty Level				
	A	**B**	**C**	**D**	
	<100%	**101-150%**	**151-175%**	**176-200%**	**>200%**
Medical	$20	$50	$100	$150	No discount, charges depend on type of visit
Behavioral	$20	$50	$100	$150	
X-ray	$0	25%*	50%*	75%*	
Labs	$15 per lab	25%*	50%*	75%*	
Prescriptions	15%*	25%*	50%*	75%*	

***calculated as a percentage of our standard fees (based on CPT billing codes)**

When further services and equipment are required as part of your treatment we partner with the following companies who offer their own discounts:

Partner Agency	Available Discount
Alaska Imaging Associates (AIA)	Ask staff for more information
Pacific Medical	Ask staff for more information
Quest lab services	Ask staff for more information

GIRDWOOD HEALTH CLINIC
Sliding Fee Discount Application

Admin only:			
Application Date		**Documentation Due Date**	

Girdwood Health Clinic's Sliding Fee Discount Program (SFDP) is based solely on family size and total family income in relation to the 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 the full charges. **Once you have qualified for the program you will be eligible for 6 months from date of qualification.**

1- Applicant Information

Name of Responsible Party: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have any of the following;

- Private Insurance: BCBS, Cigna, Aetna: _____ ☐ Yes ☐ No
- Public Insurance: Medicaid, Medicare, CHIP: _____ ☐ Yes ☐ No

2- Household Members

Name (first/last)	Relationship	DOB	Monthly Income	Employer
	SELF	X	$	
			$	
			$	
			$	

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:

Veterans Admin:	$ _____	mo / yr	Permanent Fund Dividend (PFD):	$ _____	mo / yr	Alimony:	$ _____	mo / yr
Foster Care:	$ _____	mo / yr	Work Comp:	$ _____	mo / yr	Longevity:	$ _____	mo / yr
AFDC/Welfare:	$ _____	mo / yr	Retirement:	$ _____	mo / yr	Other:	$ _____	mo / yr
Unemployment:	$ _____	mo / yr	Disability:	$ _____	mo / yr			
Soc. Security:	$ _____	mo / yr	Rental Income:	$ _____	mo / yr			

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.

☐ Current Federal Tax Return ☐ Social Security Income ☐ Pay Stub(s) Past Month ☐ Other: _____

3- Eligibility process and expectations:

☐ Initial in Box

- Eligibility/Application forms must be signed by the patients
- Proof of income submitted within **10 business** days, then reviewed and approved by Clinic staff.
- Determination of eligibility for sliding discounts will be done every six months.
- Patients qualifying for a SFDP **will be expected to pay an affordable flat fee at the time services are rendered.**
- There may be additional charges for ancillary services such as lab, x-rays and medications. See additional services slide.

*** The Girdwood Health Clinic offers free assistance with Affordable Health Care Enrollment. Would you like to meet with our Certified Application Counselor to determine your eligibility for Medicaid or low cost health Insurance?** ☐ **Yes** ☐ **No**

4 – Signature

I understand that the information I provide will be used to determine my/our ability to pay. The information above is true to the best of my knowledge. I understand that if I lie to get a reduced fee, I am committing fraud.

_____ _____

Signature Today's Date

For Office Use Only:

Total Annual Income: _____

Documents Provided: _____

Patient Notified: Y/N In Person _____ Letter _____ Date Notified: _____

Eligible Discount: $20 $50 $100 $150