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.

2021 Annual Income Eligibility Guidelines Effective January 24, 2020					
Household Size	**A**	**B**	**C**	**D**	
	100%	**101-150%**	**151-175%**	**176-200%**	**>200%**
1	$16,090	$24,135	$28,158	$32,180	No discount, charges depend on type of visit
2	21,770	32,655	38,098	43,540	
3	27,450	41,175	48,038	54,900	
4	33,130	49,695	57,978	66,260	
5	38,810	58,215	67,918	77,620	
6	44,490	66,735	77,858	88,980	
7	50, 170	75,255	87,798	100,340	
8	55,850	83,775	97,738	111,700	
For households w/more than 8, add listed amount for each person	5,680	8,520	9,940	11,360	

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:	
Date of Service:	
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. The discount will be applied to the date of service listed on the application. 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, etc: _____ ☐ 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 ☐

- 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 discounted fee(s) 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: A B C D

Girdwood Health Clinic

Statement of Financial Responsibility

Verification of Accuracy	
Initials	Please initial next to each statement below that you have read and understand
	I certify that the information in my Sliding Fee Discount Program application is true and accurate to the best of my knowledge and that submission of false information will automatically disqualify me from this program. I understand that I must notify the clinic as soon as possible and fill out a new Sliding Fee Program Application if my financial circumstances change.
	I understand that it is my responsibility to know the status, effective date, and ending date of my sliding fee and that I can call the clinic to retrieve this information. It is my responsibility to keep in contact with the clinic regarding all sliding fee scale matters, information and processes.
	I understand that I am responsible for paying the nominal fee(s) at time of service unless the urgent nature of the visit prevents payment in which case I will contact the clinic as soon as possible to arrange payment.
	I understand that I must submit proof of income within 10 business days of submitting my application and that the Slide Discount will not be applied until my application has been approved. Incomplete applications will be denied without notification from the Clinic. I understand that my application is not complete until signed by a Girdwood Health Clinic representative.

PRINT NAME_____

SIGNATURE_____

DATE_____