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 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 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: