Discount Schedule Eligibility Worksheet

Name: ___________________________ Date of Birth: _________________SSN: ________________

Last, First, MI

You must provide proof of income to qualify for the discount schedule. This information must be updated at least annually, and any time your household income size and/ or medical insurance status changes. You will be responsible for the full amount of the visit and the discount will not be applied to your account until you give IFHS the required proof of income. If proof of income is given to us within 30 days of the visit, and if you are eligible, the discount will be applied retroactively and all following visits will be discounted. Proof of income includes: prior year completed income tax forms , pay stubs from the last three months, unemployment or other benefits income receipts, and/or letters of income verification from two other individuals or from the employer(s). List your name and the names of ALL individuals who lives with you. Name, Relationship, Age, Gender, Date of Birth, Annual Income, Employer, SELF. If you need more space, please continue on the back of this form.

- Are you currently employed? ___Yes ___No
- Do you work seasonally only? ___Yes ___No
- How much money do you and all who live in your household bring in per week?
  $_______________Month $_____________ Year $ _________________
- If you are not working, how are you meeting your monthly expenses? Please check below
  Savings _____ Borrowing _______ Other________
- Do you have health insurance? ___Yes _____ No, If yes, what is the deductible amount? $ _____
- Do you have Medicaid? _____Yes _____No, Did you apply? ____Yes ____No, Were you denied? ____Yes _____ No
- Do you have Medicare? _____ Yes ______No, Are you eligible to apply? ____Yes _____No

List **ALL** that you, and those living in your household receive:

(Amount per month/year Salary or wages)

$ ________________________________ Unemployment

$_________________________________Social Security

$_________________________________Pension/Retirement

$_________________________________Rental Income/Dividends

$_________________________________Interest

$________________________________Spousal Support

$________________________________Child Support

$________________________________Foster Care

$________________________________Public Assistance (ATAP)

$________________________________Permanent Fund

$________________________________Longevity Bonus

$________________________________Self-Employed (Net Amount)

$________________________________Worker's Comp Benefits

$________________________________Disability Benefits

$________________________________Other

$________________________________Total Monthly/Annual Household Income

PLEASE READ AND SIGN

I authorize all government agencies, employers and any companies, agencies, or persons listed herein to provide information about me to Iliuliuk Family and Health Services, Inc. Community Health Center (IFHS), the State of Alaska, and/or the federal government. I also authorize IFHS to disclose this information to agencies, third party payers and other health care providers as necessary to qualify me for reduced fees. I certify that the statements regarding the persons and income in my household are 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 to notify IFHS of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential except for the purposes noted above and not be release without my written permission. I also understand that if I do not agree with any decision made concerning this application, I have the right to ask in writing for a review by the CEO.

Signature: ____ Date: ________________________________

Thank you for your cooperation!

ILIULIUK FAMILY AND HEALTH SERVICES, INC.
PO BOX 144, UNALASKA, AK 99685
TELEPHONE: 907-581-1202 FACSIMILE: 907-581-2331

EMPLOYMENT VERIFICATION FORM

Employee Name: ____________________________ Social Security Number: ___________________

The above named person has applied for the sliding scale fee at the clinic. To determine eligibility for the person/family, all earnings must be verified.

THIS SECTION MUST BE FILLED OUT BY EMPLOYER IN INK:

1. Is the person named above employed by you? _____(YES) ______(NO) Date hired: __________
   Give total gross income for previous year if worked: __________________________________
   Estimated length of employment since first hired (Months)(Years) _______________________
   Date Terminated (If Applicable) ______________________
   If Employee is or has been on leave of absence, give date leave began: ____________________
   Date of expected return: __________________Is employee seasonal? ______(YES) _____(NO)
   If yes, give current years (Regular Time) Total Income: _______________ & If applicable, contracted hours ___________________

2. How often is employee paid? _________weekly _____biweekly ____monthly ______2x monthly
   Average number of hours worked per week ____________________

3. Please state hourly wage: _________________________
4. Are there any changes in employee's pay or status during the next six months? If yes, please explain: ____
5. On the chart below, please state all earnings for the last four (4) weeks:
   PLEASE INDICATE EARNINGS BEFORE DEDUCTIONS

	DATE PAID	GROSS AMOUNT
1.		
2.		
3.		

Does the employee have health insurance? _____________ (YES) ___________________ (NO)

If yes, please fill in the information below:

Name of insurance company ____

Policy Number ____

Group Number ____

Effective Date______________________

Name(s) of Insured Dependents: _____________________________

Name of person representing the Employer: ________________________ Date: ____________________

I authorize my employer, ______________________ to release wage information to IFHS.

___________________________ ____________________

SIGNATURE OF PATIENT/ EMPLOYEE **DATE**