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 live 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? 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 or agencies or persons listed herein to provide information about me to the 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 released 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!