ILIULIUK FAMILY AND HEALTH SERVICES, INC. COMMUNITY HEALTH CENTER
Discount Schedule Eligibility Information

ELIGIBILITY FOR THIS PROGRAM IS BASED ON FINANCIAL NEED

Why does Iliuliuk Family and Health Services need to know your household income?
Some of our program budget comes from grant money. For most of these grants, income information from all of our patients is necessary to prove financial need in the communities we serve. The grant monies allow us to provide a higher level of quality and more services than we could without them. In order to get and keep these grants, we need to provide income information to prove that we are serving the people the grant money has been set aside for.

ALL INFORMATION IS CONFIDENTIAL

Definition of Household:
All members of a household who are related and pooling financial resources are counted as one family if the arrangements are considered permanent and support greater than room and board is provided.

Unrelated members of a household who are supporting one another financially are considered one family.

Definition of Income:
Income is defined as total cash before taxes from all sources, which can include:

- Wages and salaries;
- Receipts from self-employment after deductions for normal operating expenses;
- Regular payments through public assistance, social security, longevity, unemployment, strike benefits, military allotments, disability, rental income, regular support from an absent family member or someone not living in the household (includes child support), government or private pensions, and regular insurance or annuity payments;
- Income from dividends (including permanent fund), interest, rent royalties, or income from estates or trusts;
- Savings accounts (average balance of past 6 month's activity, divided by 6 months' equal monthly portion of income).

How do I qualify?
All applicants are asked to provide proof of household income and family size to qualify for discounted fees. There is a 30 day grace period from the date of your visit to the time the application needs to be returned. If the application is not returned within 30 days, you will be responsible for 100% of charges. If the application is returned within 30 days and the patient qualifies on the scale, adjustments will be made starting with the date the application was first provided to the patient. Information will be updated at least once every year, or anytime your income, household size and/or medical insurance status changes. It is your responsibility to keep an up to date sliding scale application with IFHS.

Nominal Fees:
IFHS requires that patients otherwise eligible for 100% discount pay a nominal fee of $25.00 each for medical and Behavioral Health visit, as well as $25.00 each for a laboratory or radiology visit. For a Dental visit IFHS requires that a $40.00 per visit charge be assessed as a nominal fee. An additional $15.00 fee will be charged for a one month supply or less of prescription medication or for a prescription refill. Prescription amounts will not exceed a one month supply per each nominal fee charged. Nominal fee charges are subject to change.

Excluded Charges:
The following charges are excluded from eligibility for discount:

- Dispensary stat fees.
- Dispensary's restock fees.
- After hours charges for frivolous or non-emergent care as determined by the practitioner, which a reasonable lay person would have known was non-emergent.
- Any non-emergent travel, including ambulance fees.
- Prescription charges for Viagra or Cialis.
- Plan B more than once per month
- Any cosmetic procedures.
- Any non-medically necessary procedures.

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 us the required proof 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 the 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.

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_____

Amount in Savings $_____ Bank Name _____ Acct # _____
Amount in Checking $_____ Bank Name _____ Acct # _____
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 Where 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 receiving:

	Yes	No	Amount per month/year
Salary of 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 amt)	☐	☐	_____
Worker's Comp Benefits	☐	☐	_____
Disability Benefits	☐	☐	_____
Other	☐	☐	_____

Total Monthly/Annual Household Income:_____

PLEASE READ AND SIGN OTHER SIDE OVER

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 id 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 Executive Director.

Signature: _____ Date: _____

Thank you for your cooperation!

OFFICE USE ONLY:

Total Annual Income: _____ # of Family Members: _____

Verified by:_____ Date: _____

Verified with: ☐ Pay Stubs ☐ Tax Forms ☐ EVF ☐ CVF ☐ Other _____

Proof returned (Date): _____

Discount Effective Date: _____

Qualified? ☐ **Yes** ☐ **No** Discount %: ☐ NF ☐ 75% ☐ 50% ☐ 25%

Requalify Date: _____