Kodiak Area Native Association
KANA Main Clinic | Mill Bay Health Center
SLIDING FEE APPLICATION

What is the Sliding Fee Discount Program?
The Sliding Fee Discount Program is a federal program that permits the Kodiak Area Native Association (KANA) to discount normal charges for medical, dental, and behavioral health services. KANA requires two pieces of information in order to qualify: the monthly amount of money earned in the household and the number of people who live in the household. In order to be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all persons within the household within 30 days of the date you signed this application or before your next scheduled appointment, whichever occurs first. If you fail to provide documentation you may be responsible for 100% of all charges. Falsification of this information will result in forfeiture of Sliding Fee Scale privileges.

Eligibility
All KANA patients are eligible to apply. Determination of the discount, if any, is dependent upon household income and household size in comparison to the current Alaska Federal Poverty Guidelines. The discount may apply to Insurance/Medicare deductibles as well as non-covered services. The discount does not apply to insurance co-pays.

Term
Information must be updated annually from time of application or if there are any significant life events.

Definitions and Examples of Acceptable Proof Required

I. Income Determination
   a. Income is based on the gross income of all household members earning income.
      i. Includes earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.
      ii. Noncash benefits (such as food stamps and housing subsidies) do not count.
      iii. Before taxes.
      iv. Excludes capital gains or losses.
      v. If a person lives with a family, add up the income of all members in the household.
   b. Acceptable forms of proof for determining income include the following:
      i. Income Tax Return: A signed copy of the most recent tax return showing Adjusted Gross Income.
      ii. Pay check stubs: Two or more consecutive pay stubs indicating gross pay within the past thirty (30) days.
      iii. Agency letter: A letter from the Social Security Administration, Veterans Administration or Social Service Agency (i.e., Food Stamps or WIC) indicating income level.
      iv. Unemployment Verification: Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of unemployment compensation being received.

II. Household Size Determination
   a. All members of a household who are pooling financial resources including room and board and/or are supporting on another financially are counted as one household.
   b. Household size can be documented with any of the following:
      i. A copy of the most recent tax return showing household size
      ii. Social Security Card
      iii. Birth Certificate
      iv. Medicaid Cards for any dependent children
      v. Driver's License or State ID card

*****KEEP THIS PAGE FOR YOUR REFERENCE*****

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Applicant Full Name: _____ Date of Birth _____
Mailing Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Full Name	Relationship to Applicant	Birth Date	Income Type*	Monthly	Total
SELF	SELF	SELF			
				Total Income: *(to be completed by staff)*	

Documentation must be submitted within 30 days or before the next scheduled appointment, whichever occurs first.

I certify that the above facts are true and correct to the best of my knowledge. I am also aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination from the Sliding Fee Discount Program.

Patient Signature: _____ Date: _____
Signature of parent/guardian: _____ Date: _____

STAFF USE ONLY

***Income type received**

☐Pay stubs for 1 month ☐Unemployment Benefit Statement ☐Worker's compensations ☐SSA/SSI/APA Printout ☐Retirement income	☐Public Assistance ☐Veteran's Payments ☐Dividends ☐Food Stamps Printout/Benefit Letter
Patient MRN:	Staff Initials
Date Documentation Received:	