



KODIAK AREA NATIVE ASSOCIATION
HEALTH SERVICES

Sliding Fee Discount Program Application

What is the Sliding Fee Discount Program?

The Sliding Fee Discount Program is a Federal program that allows KANA to discount our normal and customary charges for uninsured or under-insured patients. The Sliding Fee Discount Program offers a flat rate fee for service based on a patient's ability to pay. The flat rate discount fee schedule is available upon request. The program covers office visits and limited laboratory tests for Medical, Dental, and Behavioral Health Services. Services not provided on the Sliding Fee Discount Program include x-rays and additional outside laboratory tests. Patients will receive a separate bill for x-ray and/or laboratory tests from providers outside of KANA.

Eligibility

All KANA patients, including all family members listed on the application, may apply to receive discounted fees based on their ability to pay. Determination of the discount, if any, is dependent upon proof of household income and household size in comparison to the current Alaska Federal Poverty Guidelines. The sliding fee discount may apply to public or private insurance deductibles, co-insurances, and/or co-pay amounts depending upon legal and contractual obligations with individual insurance companies.

Terms

Eligibility information must be updated annually from the time of application and/or whenever there is a change of income for any household members.

Acceptable Proof of Eligibility

- I. Income determination
 - a. Income is based on the gross income of all household members' earning income. Gross income represents the patient's and household members' total personal income before taxes or other deductions. A patient may initially self-report gross family income at their first visit but will be required to provide supporting documentation within 30 days or before their next visit, whichever occurs first, if they wish to continue to receive the discount.
- II. Patients and household members are to provide all applicable proof of income documents, which may include:
 - i. At least a 4 week period of paycheck stubs
 1. Paid weekly, at least 4 consecutive stubs
 2. Paid bi-weekly or semi-monthly, at least 2 consecutive stubs
 3. Paid monthly, at least 1 paycheck stub
 - ii. Most recent available income tax return, 1099 form or W-2
 - iii. Unemployment award letter or copy of last unemployment check

- iv. Disability/Social Security award letter or copy of check or bank record
- v. One pension or retirement check or bank record
- vi. Child support verification: copy of check, court papers indicating support amount, or notarized letter from parent making payment
- vii. Worker's Compensation payment
- viii. VA benefits payment record
- ix. Rental property income documentation

III. Household size determination includes all members of a household living at the same address:

- i. Patient
- ii. Spouse
- iii. Registered domestic partner
- iv. Unmarried partners with common children
- v. Unmarried partners living as married/cohabitation
- vi. Parents
- vii. Children (biological, adopted, foster, step, legal ward or child of registered domestic partner)

IV. Zero Income Statement

- a. Patients claiming to have zero income, will be required to complete and sign a Zero Income Statement

Alternate Resources

You and your family may be eligible for alternate health care resources, such as: Medicaid, Medicare, Denali KidCare, and VA Benefits. KANA's Alternate Resource Specialists are available to discuss your health insurance options, and will assist with determining eligibility and completing the associated paperwork. Call 907-486-9870 to learn more.

If you have or become eligible for other resources to cover expenses associated with your healthcare needs (health insurance, Medicaid, Medicare, and/or VA Benefits) please provide this information to KANA upon your visit or as soon as you are aware of alternate coverage. Providing an insurance card is the preferred method, but KANA will accept verbal information over the phone. Billing the appropriate insurance will extend current funds to serve you and other KANA patients.

*****KEEP PAGES 1-2 FOR YOUR REFERENCE*****



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Applicant Full Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Total Household Members: _____

Please complete the following information for all household members, including yourself:

Full Name	Relationship to Applicant	Birth Date	Income Type*	Monthly	Total
	SELF				
				Total Income:	
				<i>To be completed by staff</i>	

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 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: _____

Parent/Guardian Signature: _____

Date: _____

STAFF USE ONLY

Discount Level: A B C D

***Income Type Received**

<input type="checkbox"/> Pay Stubs for a 4 week period <input type="checkbox"/> unemployment benefit statement or check <input type="checkbox"/> Worker's Compensations <input type="checkbox"/> SSA/SSI/APA Printout <input type="checkbox"/> Public Assistance	<input type="checkbox"/> Veteran's Payments <input type="checkbox"/> Dividends <input type="checkbox"/> Retirement Income <input type="checkbox"/> Other:
Patient MRN: _____	Staff Initials: _____
Date Documentation Received: _____	