KODIAK AREA NATIVE ASSOCIATION
HEALTH SERVICES

Sliding Fee Discount Program Application

Sliding Fee Discount Program

The Sliding Fee Discount Program (SFDP) is a Federal program that allows KANA to discount our normal and customary charges for eligible patients. The Sliding Fee Discount Program offers discounted flat rate fees for service based on a patient's ability to pay. The program covers office visits for Medical, Dental, and Behavioral Health Services, as well as limited laboratory services. Patients will receive a separate bill for services from providers outside of KANA. Services provided by Providence Kodiak Island Medical Center are not covered by KANA's SFDP, but PKIMC does have their own discount programs available.

At KANA, no patient will be denied services due to an inability to pay.

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:
   a. 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

b. Most recent available income tax return, 1099 form or W-2
c. Unemployment award letter or copy of last unemployment check
d. Disability/Social Security award letter or copy of check or bank record
e. One pension or retirement check or bank record
f. Child support verification: copy of check, court papers indicating support amount, or notarized letter from parent making payment
g. Worker's Compensation payment
h. VA benefits payment record
i. Rental property income documentation

III. Household size determination includes all members of a household living at the same address who support each other financially and/or share resources, this may include:
   a. Patient
   b. Spouse
   c. Registered domestic partner
   d. Unmarried partners with common children
   e. Unmarried partners living as married/cohabitation
   f. Parents
   g. 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, VA Benefits, Tribally-Sponsored Health Insurance Program (T-SHIP) or other types of insurance. KANA's Patient Benefit Coordinators are available to discuss your health insurance options, and will assist with determining eligibility and completing the associated paperwork. Call 907-486-9861 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*****

KANA – Sliding Fee Discount Program

Income Table					
Percent of Federal Poverty Guidelines		Up to 100%	101%-150%	151%-175%	176%-200%
Household Size	**Income Measure**	**Category A**	**Category B**	**Category C**	**Category D**
1	Annual	$0 - $19,550	$19,551 - $29,325	$29,326 - $34,213	$34,214 - $39,100
	Monthly	$0 - $1,629	$1,630 - $2,444	$2,445 - $2,851	$2,852 - $3,258
2	Annual	$0 - $26,430	$26,431 - $39,645	$39,646 - $46,253	$46,254 - $52,860
	Monthly	$0 - $2,203	$2,204 - $3,304	$3,305 - $3,854	$3,855 - $4,405
3	Annual	$0 - $33,310	$33,311 - $49,965	$49,966 - $58,293	$58,294 - $66,620
	Monthly	$0 - $2,776	$2,777 - $4,164	$4,165 - $4,858	$4,859 - $5,552
4	Annual	$0 - $40,190	$40,191 - $60,285	$60,286 - $70,333	$70,334 - $80,380
	Monthly	$0 - $3,349	$3,350 - $5,024	$5,025 - $5,861	$5,862 - $6,698
5	Annual	$0 - $47,070	$47,071 - $70,605	$70,606 - $82,373	$82,374 - $94,140
	Monthly	$0 - $3,923	$3,924 - $5,884	$5,885 - $6,864	$6,865 - $7,845
6	Annual	$0 - $53,950	$53,951 - $80,925	$80,926 - $94,413	$94,414 - $107,900
	Monthly	$0 - $4,496	$4,497 - $6,744	$6,745 - $7,868	$7,869 - $8,992
7	Annual	$0 - $60,830	$60,831 - $91,245	$91,246 - $106,453	$106,454 - $121,660
	Monthly	$0 - $5,069	$5,070 - $7,604	$7,605 - $8,871	$8,872 - $10,138
8	Annual	$0 - $67,710	$67,711 - $101,565	$101,566 - $118,493	$118,494 - $135,420
	Monthly	$0 - $5,643	$5,644 - $8,464	$8,465 - $9,874	$9,875 - $11,285

Services*	Category A	Category B	Category C	Category D
Medical	$0	$35	$50	$60
Medical – Labor & Delivery	$500	$1,000	$1,500	$2,000
Behavioral Health	$0	$35	$50	$60
Dental - Preventative	$0	$60	$70	$90
Dental – Restorative & Elective	$40	$90	$100	$120
Dental – Crowns	$337	$775	$875	$975
Dental – Partial Dentures	$412	$925	$1,025	$1,125
Dental – Dentures	$475	$1,050	$1,150	$1,250

HOUSEHOLD SIZE: All members of a household living at the same address that are related or unrelated and who support each other financially and/or share resources are counted as one household. This may include: patient, spouse, registered domestic partner, unmarried partners with common children, unmarried partners living as married/cohabitating, parents, and children (biological, adopted, foster, step, legal ward, or child of registered domestic partner).

INCOME: Gross income is defined as an individual's total personal income before taxes or other deductions.

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***MEDICAL:** Radiology and some laboratory test fees are EXCLUDED from the flat rate fee. Patients will receive a separate bill from radiology providers and/or reference laboratories for tests performed by providers other than KANA.

***MEDICAL – LABOR & DELIVERY:** The flat rate fee is for Labor and Delivery services ONLY. All prenatal services will follow the medical sliding fee schedule. The flat rate fee for Labor and Delivery services will only apply to charges from KANA providers; patients will also receive a separate bill for inpatient services from the hospital.

***DENTAL – PREVENTATIVE:** Preventative Dental Services include oral exams, x-rays, sealants, fluoride varnishes, and/or basic prophylaxis (cleanings). These services may be rendered in one visit or may require multiple visits. Each visit will require a separate flat rate fee.

***DENTAL – RESTORATIVE & ELECTIVE DENTAL SERVICES:** Restorative and Elective Dental services include, but are not limited to: fillings (amalgam or composite), root canals, space maintainers, periodontal scaling, root planning, and extractions. These services may be rendered in one visit or may require multiple visits. Each visit will require a flat rate fee to be paid at the time of the appointment. A single visit that requires two or more extractions will result in two or more flat rate fees - one fee per extraction. Complicated extractions may incur additional costs and will be assessed on a case-by-case basis.

***DENTAL – CROWNS:** A single visit that requires two crowns will result in TWO flat rate fees – one fee per crown.

***DENTAL – PARTIAL DENTURES:** A single visit for upper and lower dentures will result in TWO flat rate fees.

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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: *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 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**

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