

# Sliding Fee Discount Application



## IMPORTANT: Remember to Reapply for the Sliding Fee Discount Program Every 12 Months

Remember to complete a new Sliding Fee Discount application every twelve months or any time that your household size or annual household income changes.

## About the Sliding Fee Discount Program at ANHC

**The Anchorage Neighborhood Health Center (ANHC) offers a Sliding Fee Discount Program that reduces the cost of health care for eligible patients.**

All patients are encouraged to apply, even if you have health insurance. If you are eligible, your discount will apply to charges that your insurance does not pay. For those without insurance, the discount will apply to all costs of care you have at ANHC.

Your eligibility for the program and the amount of your discount are based on your household size and annual income. Your discount applies to all services at ANHC, including prescription medications from our pharmacy.

## Services Eligible for the Sliding Fee Discount

The sliding fee discount program applies to all services provided directly by ANHC, including prescription medications from ANHC's pharmacy.

*Please note: Your sliding fee discount may not apply to some situations where you have samples processed at an outside lab (for example, Labcorp) even if the sample was taken at ANHC. Your sliding fee discount also does not apply to services you receive from outside providers or clinics, even if you were referred to the provider or clinic by your ANHC provider.*

## How do you know if you are eligible for a sliding fee discount?

ANHC's Sliding Fee Discount Program reduces the cost of health care for eligible patients. Your eligibility for the program and the amount of your discount are based on:

- Household size
- Annual income

## What is considered a household?

**A household includes everyone who shares resources and depends on the same income.** Your household members may or may not be related to you. They may or may not live with you.

### **These arrangements are considered one household:**

- Both related and unrelated individuals who share resources and depend on the same income.
- Both married and unmarried individuals who share resources and depend on the same income.
- An adult child (19 years old and older) who is claimed as a dependent on a parent or guardian's tax return, even if they do not share resources or depend on the same income.

### **These arrangements are considered separate households:**

- Adult children (individuals 19 years old or older) who are not claimed as a dependent on a parent or guardian's tax return, do not share resources, and do not depend on the same income.
- Anyone (related or unrelated) living in the home on a temporary basis.

## How do you determine what your household income is?

**To be considered for the Sliding Feed Discount Program, you must provide proof of all income for everyone in your household.** The proof of income must show the pre-tax total.

**Income includes but is not limited to:** salary, wages, unemployment compensation, worker's compensation, Social Security, Supplemental Security income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trust fund income, alimony, Alaska Permanent Fund Dividend, and assistance from friends or family.

## What is considered proof of income?

### **Proof of income includes:**

- **Benefits verification letter:** Letter verifying your Social Security, Medicaid, Veterans Administration, or social service agency (food stamps, Alaska Housing, etc.) benefits.
- **Court documents:** Official documents stating child support and/or alimony amount as awarded by a judge.
- **Employer letter:** Letter from your employer on company letterhead stating your current gross monthly income and frequency of pay periods. (Acceptable only if you do not have a recent pay stub. You must also provide employer contact information.)
- **Income tax return:** Signed copy of your most recent income tax return showing your adjusted gross income and supporting schedules for business income and/or investments.
- **Official paperwork:** Paperwork documenting retirement, disability, SSI and/or SSA benefits.
- **Pay stubs:** One month of pay stubs showing your gross income.
- **Unemployment verification:** Paperwork proving unemployment status and the amount of unemployment compensation being received.

You will need to bring proof of income for all members of your household to submit with your Sliding Feed Discount Program application.

## What if I don't have anything to prove my household income?

If you are unemployed and/or do not have any source of verifiable income, or if you do not have proof of income for everyone in your household who earns income, you will be asked to complete an additional form called the Self Declaration of Income. Talk to our staff about whether they think this would be a good option for you.

## Self-Declaration of Income Options

**If you do not have the needed documents to provide proof of income for yourself or others in your household, you will be asked to complete a self-declaration of income.** This temporary discount is valid for 30 days. You must provide proof of household income within 30 days to continue to receive the discount. You may only use the temporary self-declaration of income once every twelve months.

**If you will not be able to collect the needed documents within this 30-day period, tell our staff. A one year self-declaration of income may be an option for you.**

## Important reminder about accurate information

If you provide false information, you will not be eligible for the Sliding Fee Discount Program.

This Sliding Fee Discount Application is subject to independent verification by the ANHC Finance Office, which may result in a determination that is different than the one provided on the current date.

# Sliding Fee Discount Chart



Use this chart to calculate your estimated sliding fee discount.

1. In table 1, find the row with your household size.
2. In the same row, find the box with your household's total income.
3. Note which column that box is in—A, B, C, D, or E.
4. In table 2, find the column with the matching letter.
5. The charges listed in that column are about what you can expect to pay for the service.

**Example:** Your household size is 3. Your household's annual income is \$45,000. You are in column C.

Table 1: Find Your Discount					
	Column <b>A</b>	Column <b>B</b>	Column <b>C</b>	Column <b>D</b>	Column <b>E</b>
Household size: <b>1</b>	\$18,210 or Less	\$18,211 to \$24,219	\$24,220 to \$30,229	\$30,230 to \$36,420	More than \$36,420
Household size: <b>2</b>	\$24,640 or Less	\$22,641 to \$32,771	\$32,772 to \$40,902	\$40,903 to \$49,280	More than \$49,280
Household size: <b>3</b>	\$31,070 or Less	\$31,071 to \$41,323	\$41,324 to \$51,576	\$51,577 to \$62,140	More than \$62,140
Household size: <b>4</b>	\$37,500 or Less	\$37,501 to \$49,875	\$49,876 to \$62,250	\$62,251 to \$75,000	More than \$75,000

Table 2: Examples of Charges					
	Column <b>A</b>	Column <b>B</b>	Column <b>C</b>	Column <b>D</b>	Column <b>E</b>
Medical	\$20	\$30	\$40	\$50	No discount available.  Charges will depend on the type of visit or services you have.
Behavioral	\$5	\$10	\$15	\$20	
Nutrition	\$5	\$10	\$15	\$20	
Dental visit A	\$40	\$50	\$70	\$80	
Dental visit B	\$85	\$110	\$140	\$175	
Lab visit	\$15	\$30	\$45	\$60	
X-ray visit	\$20	\$40	\$60	\$80	

## Notes

- Dental supplies and lab costs are charged in addition to the visit charge.
- Dental visit A includes exams, cleanings, extractions, and fillings. Dental visit B includes crowns, root canals, and partials.
- Pharmacy discounts will vary by medication. Please see pharmacy staff for more information.
- **Each column represents a percentage of the Federal Poverty Level.** Column A represents 100% or less, Column B represents 101% to 133%, Column C represents 134% to 166%, column D represents 167% to 200%, and Column E represents more than 200%.

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# Sliding Fee Discount Application



Applicant Information			
Name of responsible party (first and last)			Date of birth
Home phone		Cell phone	
Mailing address	City	State	Zip code
Do you have any of the following types of insurance? Circle any insurance(s) that you have.			
Medicaid   Medicare   Denali KidCare   Blue Cross/Blue Shield   Cigna   Aetna   TRICARE Other Insurance _____   I don't have any insurance			
Providing Proof of Income			
Are you currently receiving income from any source? (circle answer)		<b>YES</b>	<b>NO</b>
Do you have documents with you today that can provide proof of your current household income? (circle answer)		<b>YES*</b>	<b>NO</b>
Within 30 days from now, will you be able to provide documents that can provide proof of your current household income? (circle answer)		<b>YES</b>	<b>NO</b>
If you are not currently receiving any income, how do you meet your living expenses? Please provide examples.			
Do you want to talk with a staff member to ask about completing a self-declaration for your household income?		<b>YES</b>	<b>NO</b>
Household Information (include children and those with no income)			
<b>Name of household member #1</b>		Relationship to you	Date of birth
		<b>Self</b>	
#1 Household member's total annual income? \$ _____ Check all income sources that apply...			
<input type="checkbox"/> Job <input type="checkbox"/> Self-employment <input type="checkbox"/> Pension/retirement <input type="checkbox"/> Unemployment benefits <input type="checkbox"/> PFD <input type="checkbox"/> Social Security <input type="checkbox"/> Adult Public Assistance <input type="checkbox"/> Other:			
<b>Name of household member #2</b>		Relationship to you	Date of birth
#2 Household member's total annual income? \$ _____ Check all income sources that apply...			
<input type="checkbox"/> Job <input type="checkbox"/> Self-employment <input type="checkbox"/> Pension/retirement <input type="checkbox"/> Unemployment benefits <input type="checkbox"/> PFD <input type="checkbox"/> Social Security <input type="checkbox"/> Adult Public Assistance <input type="checkbox"/> Other:			

<b>Name of household member #3</b>		Relationship to you	Date of birth			
#3 Household member's total annual income? \$ _____ Check all income sources that apply...						
<input type="checkbox"/> Job	<input type="checkbox"/> Self-employment	<input type="checkbox"/> Pension/retirement	<input type="checkbox"/> Unemployment benefits			
<input type="checkbox"/> PFD	<input type="checkbox"/> Social Security	<input type="checkbox"/> Adult Public Assistance	<input type="checkbox"/> Other:			
<b>Name of household member #4</b>		Relationship to you	Date of birth			
#4 Household member's total annual income? \$ _____ Check all income sources that apply...						
<input type="checkbox"/> Job	<input type="checkbox"/> Self-employment	<input type="checkbox"/> Pension/retirement	<input type="checkbox"/> Unemployment benefits			
<input type="checkbox"/> PFD	<input type="checkbox"/> Social Security	<input type="checkbox"/> Adult Public Assistance	<input type="checkbox"/> Other:			
<b>Name of household member #5</b>		Relationship to you	Date of birth			
#5 Household member's total annual income? \$ _____ Check all income sources that apply...						
<input type="checkbox"/> Job	<input type="checkbox"/> Self-employment	<input type="checkbox"/> Pension/retirement	<input type="checkbox"/> Unemployment benefits			
<input type="checkbox"/> PFD	<input type="checkbox"/> Social Security	<input type="checkbox"/> Adult Public Assistance	<input type="checkbox"/> Other:			
<b>Name of household member #6</b>		Relationship to you	Date of birth			
#6 Household member's total annual income? \$ _____ Check all income sources that apply...						
<input type="checkbox"/> Job	<input type="checkbox"/> Self-employment	<input type="checkbox"/> Pension/retirement	<input type="checkbox"/> Unemployment benefits			
<input type="checkbox"/> PFD	<input type="checkbox"/> Social Security	<input type="checkbox"/> Adult Public Assistance	<input type="checkbox"/> Other:			
<b>Health Insurance Enrollment Assistance</b>						
<b>Anchorage Neighborhood Health Center offers free assistance with Affordable Care enrollment.</b> Would you like to meet with our Certified Application Counselors to determine your eligibility for Medicaid or other low cost health insurance options?						
						<input type="checkbox"/> Yes
						<input type="checkbox"/> No
<b>Signature</b>						
<b>I declare that the above information and supporting documents are true and correct to the best of my belief and knowledge.</b> I understand it is my responsibility to inform ANHC of any changes to my income that may affect my eligibility for sliding fee discounts or participation in discount drug programs. I understand that if I falsify any information to fraudulently receive services, including but not limited to medical, dental, lab, x-ray, or prescription drug benefit programs, my participation will be revoked and I will be responsible for 100% of the usual and customary charges of ANHC.						
<b>I understand that payment for services provided by ANHC is due at the time of service. I understand that ANHC staff may verify the information in this form.</b>						
Signature					Today's date	
<b>Office Use Only</b>						
<i>Account number</i>	<i>Date provided</i>	<i>Date due back</i>	<i>Date returned</i>	<i>Date scanned</i>	<i>PSR</i>	