Application received at: _____ (Clinic)	2019 Sliding Fee Discount APPLICATION	SEARHC SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

Last Name	First name	Primary Phone	Date of Service
Mailing Address	City	State	Zip

Household Information				Insurance Status				Ethnicity	Race (please check one)					
Last Name	First Name	Relationship to applicant	DOB	None	Medicaid	Medicare	Private	Hispanic/ Latino? (Yes/ No)	AK Native / Amer. Indian	White	Asian	Black/ African Amer.	Other Pacific Islander	More than one race
1														
2														
3														
4														
5														
6														
7														
8														

Please circle your household size and the income for that household size in the column(s) below.

Household size	Monthly Income													
	Homeless: Level 0 ($0 Co-Pay)		Level 1: $25 Co-Pay		Level 2: $50 Co-Pay Medical and BH Dental 75%		Level 3: $75 Co-Pay Medical and BH Dental 50%		Level 4: $100 Co-Pay Medical and BH Dental 25%					
1	Up to	$1,300		Up to	$1,950		Up to	$2,275		Up to	$2,600		Check if income is Greater than Level 4: _____	
2		$1,761			$2,641			$3,081			$3,522			
3		$2,222			$3,333			$3,888			$4,443			
4		$2,683			$4,024			$4,694			$5,365			
5		$3,143			$4,715			$5,501			$6,287			
6		$3,604			$5,406			$6,307			$7,208			
7		$4,065			$6,098			$7,114			$8,130			
8		$4,526			$6,789			$7,920			$9,052			
	Each Additional member add: $461				$691			$806			$922			

Household is defined as all members of a family, related or unrelated, who are living together & pooling financial resources, if the arrangements are considered permanent & support greater than room and board is provided.

Return Application to clinic by (date):

Entered in: Cerner ☐ Entered in: Sharepoint ☐ Letter/card sent to patient ☐ Card scanned into EHR ☐

Please read the following statements, initial each one, and sign below to show you are in agreement:

SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

_____ I have been advised that I must submit an application and provide proof of income to the clinic within 10 days to receive a discount for any future visits. If I do not provide proof of income within the 10 day period, I will be required to pay 100% of future costs.

_____ I understand that the HRSA Sliding Discount cannot be used for inpatient hospital stays. The SEARHC Financial Assistance Policy may be available to help cover costs associated with hospitalization. Eligibility criteria for the SEARHC Financial Assistance Policy will apply.

_____ I understand that the Sliding Discount does not cover prescriptions filled at a non-SEARHC pharmacy, and will not cover cosmetic procedures.

_____ I agree to apply for any alternative resource programs for which I or my household members are eligible, such as Medicaid.

_____ I authorize SEARHC to verify information on my application. I understand that a deliberate misrepresentation is considered fraud, and is punishable by law.

_____ I authorize SEARHC to release information regarding my visits to my insurance company or other third party payer, and for payment to be made directly to SEARHC.

_____ I understand that the information provided here will be kept confidential except as noted above.

_____ I certify that the statements made on the application regarding my household, income, and all other items that pertain to eligibility are true and complete to the best of my knowledge.

_____ _____

Signature of Applicant or Authorized Representative Date Signature of SEARHC Employee Receiving Application Date

FOR OFFICE USE ONLY

Verified By _____ Date Application Received _____

SD Level: **0 1 2 3 4** Over Income Coverage Eligibility Date _____ Comments:

_____

Form revised 3.8.18