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|  | | | **Seward Community Health Center**  PO Box 2895 / 417 First Avenue  Seward, AK 99664  www.sewardhealthcenter.org  **907-224-2273** | | | | | | | | **SLIDING FEE DISCOUNT PROGRAM**  **APPLICATION** | | | | |
| **Applicant Name:** | |  | | | | | | | | **Date of Birth:** | | | |  | |
| **Physical Address:** | |  | | | | | | | | | | | | | |
| **Mailing Address:** | |  | | | | | | | | | | | | | |
| **Home Phone:** |  | | | | **Cell Phone:** |  | | | **Work Phone:** | | | |  | | |
| **Household Member Name** | | | | **Relationship to Applicant** | **Date of Birth** | | **Employment Status (Full, Part, Unemp.)** | **Income** | | | | **Social Security Number** | | | **Employer** | |
|  | | | | Self |  | |  | $ | | | |  | | |  | |
|  | | | |  |  | |  | $ | | | |  | | |  | |
|  | | | |  |  | |  | $ | | | |  | | |  | |
|  | | | |  |  | |  | $ | | | |  | | |  | |
| Are you eligible for VA benefits?  Yes  No | | | | | | | Do you need prescription assistance?  Yes  No | | | | | | | | | |
| Do you have insurance?  Yes  No If yes, who is your carrier? | | | | | | |  | | | | | | | | | |
| Will the nominal fee of $20 prevent from you accessing health care at SCHC?  Yes  No | | | | | | | | | | | | | | | | |
| “I agree with the above, whether I sign as a patient or the guarantor or another, that I am responsible for the account balance in accordance with the regular rates and terms of Seward Community Health Center (SCHC). In the event this account is referred to a collection agency I shall pay all delinquent accounts and any accrued interest. I declare the information provided on this application along with the supporting documentation is true and correct to the best of my belief and knowledge. Furthermore, I understand that it is my responsibility to inform SCHC of any changes to my income that may change my eligibility for sliding fee discounts or for participation in discount drug programs.”  “The sliding fee discount shall be effective for dates of service 90 days prior to the eligibility determination date and one year after the determination date.  Application of the discount outside of the 15-month period shall be approved by the Executive Director.”  “I consent to the release of any and all of my financial records including but not limited to: sliding fee scale application and supporting documentation, patient information, insurance information, and any other types of information contained within my electronic health and/or dental records that may be deemed necessary for review by any auditor, for participating in any assistance programs including but not limited to sliding fee scale, grant-funded programs and/or pharmacy assistance programs for which I may be eligible.”  “I understand that should SCHC become aware that any of this information has been falsified to fraudulently receive medical services or programs, my participation will be revoked and I will be responsible for 100% of the usual and customary charges of SCHC.”  “I understand that I will be required to submit a Sliding Fee Discount Program application and provide financial proof of income annually.”  **X**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Applicant Date | | | | | | | | | | | | | | | | |