Approved Discount:

Sliding Fee Program Application

Clinic Site:_____

Patient HRN #: _____

Name:_____ Date: _____

Mailing Address: _____

PO Box or Street Town State Zip Code

Home Phone No._____Cell Phone No._____Email: _____

Have you been enrolled in the Sliding Fee Program before? Yes No

HOUSEHOLD INFORMATION

Please list ALL MEMBERS of your household (include yourself). Include those who contribute to the household income and all persons for whom you are financially responsible or those you can claim on your taxes. **If child is over 18, indicate if student.**

Name	Birth Date	Relationship to Applicant
		Self

_____I have no health insurance coverage

_____I have health insurance coverage through_____.

If you have insurance, we will bill your insurance carrier and apply the discount to any balance due for co-pays and deductibles.

Please fill out the income information section below for ALL members of your family. Bring current pay stubs, recent Federal Income Tax Return or/and any income source receipts listed below

INCOME INFORMATION		
Sources of Income	**Name of Source**	**Gross Annual/Hourly Income**
Wages		
Self-employed (net receipts after deductions)**		
Social Security Benefits (SSI, Survivor's, Disability)		
Public Assistance (TANF, General Assistance, etc.)		
Child Support/Alimony		
Unemployment Benefits, Workers' Compensation		
Stocks, Dividends, Rental Property		
Interest Income		
Previous Income Tax		
Other (Pensions, Veteran's Benefits, Union, etc.		

****If you are self-employed, you must provide your most recent Federal Income Tax Return (1040).**

YOU MUST INCLUDE PROOF OF INCOME SUCH AS PAYCHECK STUBS, COPIES OF UNEMPLOYMENT CHECKS AND/OR SOCIAL SECURITY CHECKS.

Without proof of income our application will not be processed and your enrollment into the program will be delayed. If you have difficulty getting proof of income, speak to the EAT's Customer Service Representative who can assist in recommending sources of proof. If there are special issues you feel should be considered when we review your application, please include on a separate piece of paper.

ZERO INCOME

PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer:_____ Date of last employment: _____
Please provide a letter from whom you're living with, explaining how you are meeting your basic needs the list below

I,_____, certify that I have had no source of income since_____.

All Applicants: PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW.

- I agree to be responsible for my Eastern Aleutian Tribes Medical bills.
- I also agree to tell the Eastern Aleutian Tribes if I become eligible for any other form of coverage.
- I understand that if I provide false or incomplete information, I may no longer qualify for a fee discount.
- I certify that the above information on this application is correct and all sources of income required have been reported. I further understand that I will need to update my application annually even if no changes occur.

Signature:_____ Date: _____

EAT Billing office Use Only:

Total No of Family Members: _____
Yearly Income:_____
Verification Source: _____

Approved sliding Fee Discount: _____
Renewal Date: _____

Manager Signature: _____