Aleutian Pribilof Islands Association, Inc.

Sliding Fee/Discount Schedule Application

Name: ________________________________ SSN#___________________ Date of Birth: ________

Mailing Address_______________________________________ Home Phone: _________________

Employers Name______________________________________ Work Phone: _________________

Unemployed: Please provide letter of verification from two individuals
Self-employed: Please provide current income tax forms.

Do you work seasonally? No Yes **How many months**?__________________

Have you worked on a boat/fishing vessel within the past year? No Yes

If yes, please provide boat's name, captain's name, address and telephone number:

____

Do you have health insurance? No Yes

Medicare No Yes

Private Health Insurance No Yes

Medicaid or Denali Kid Care No Yes **Have you ever applied for either?** No Yes

If yes to any insurance questions above, please give a copy of the front and back of the card and please answer these questions:
Effective date:__________ **Who is the insurance under**:______________________________

Date of birth of insured: _______________

List all members (people) in the household:

Full Name	Relationship	Date of Birth	Income (Report monthly or annual income only)
		Total Monthly or Annual Income	

For additional space, please use the back of the form

Please check which type of proof of income that was given:

___ Salary/Wages	___ Unemployment	___ Self-Employed	Other_________
___ Social Security	___ Pension/Retirement	___ Workers' Compensation	
___ Alimony	___ Child Support	___ Foster Care	
___ Public Assistance/APA	___ Native Corporation Dividends	___ Stipends Rental Income	

I hereby authorize the representatives of APIA to verify information provided on this application. I authorize my insurance benefits to be paid directly to APIA and authorize to release information regarding my office visits to my insurance company or other third party to see settlement of my account. I certify that the statements regarding the persons and income in my household are true and correct. I understand I may be responsible for the full amount of my visit if the information is found to be inaccurate and I may be denied a discount for knowingly providing false information.

The information provided herein will be kept confidential and I agree to notify APIA primary care or behavioral health of any changes in income, address and number of household members. I have been advised that I must provide proof of income within the 15 calendar day grace period which will expire on___________________ and if not, then I will be required to pay 100% of the fees. I am aware that the discount fee discount is a payment of last resort. If I qualify for other resources; such as Medicaid and/or Denali Kid Care I must comply with the APIA discount fee policy. Medical services will not be denied based on ability to pay.

Signature of Applicant: ____

Date: _______________________

TO BE FILLED OUT BY OFFICE STAFF ONLY

Employment Verification:

Verified with: ( ) Pay Stubs ( ) Tax Forms ( )

Other:____

Program applicant may qualify for: ( ) Medicaid ( ) Denali Kid Care

( ) Approved ( ) Not qualified-Over Income

Eligibility Date:__________________ **Renewal Date**:_______________

Applicant Discount: ( ) 100% ( ) 75% ( )50% ( ) 25% ( ) Nominal Fee

Verified By:____Date:__________