Island Health Care

Island Health Care Sliding Fee Discount Application

How Does the Sliding Fee Scale Work?

As a Federally Qualified Health Center (FQHC), Island Health Care provides a sliding fee discount to patients who are income eligible. Even if you have insurance, you may still be eligible for a sliding fee. To determine if you are eligible for this discount you will need to fill out and sign this application. In addition to this application, you will need to provide IHC with the following documents to apply for the sliding fee discount:

Proof of income for you and any family household members. The following items may be used as proof of income:

- Two most recent pay stubs
- Most recent income tax returns with attached W-2s and/or 1099s
- Employer letter: For those not receiving an actual paycheck, a letter from your employer detailing current gross income and frequency of pay periods may be accepted. Contact information must be provided so that the information can be verified.
- Any other income documentation (i.e. statement of unemployment benefits, social security benefit letter, public assistance benefits letter, etc.)
- Self-declaration of zero income

Please attach copies of all documents or self-declaration statements being used as proof of income. **If you need help filling out this form or have any questions, please call our Community Health Worker Sarah Toste at 339-201-3989.**

NOTE: Under federal regulations, in order to provide you with a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. Your annual income and your family size will be used to calculate your discount. You must verify your income every year. IHC conducts all annual sliding fee renewals in April, because it is easier for patients to get their income verification documents during tax season. Please remember to hold on to your tax documents in April, and IHC will be in touch to renew your eligibility for the sliding fee program!

Applicant's Full Name (first, middle, last):	Today's Date:
Mailing Address:	Date of Birth (MM/DD/YYYY):
City, State, Zip Code:	Primary Phone Number (best number to reach you at):

Are you covered by or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veterans' benefit, Medicaid (MassHealth), and/or Medicare? ☐YES ☐NO

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If yes, please provide the following information:

Policy Holder (Full Name):_____ Insurer:_____
Policy Number:_____

Family Household Members & Gross Income (ex. dependent children, spouse/partner).

Proper proof of income documents must be provided for each family household member.

Number of immediate family members in household: _____ *Please list each household member below:*

Name	Date of Birth	Relationship	Employed?	Annual Income
			Yes / No	$
			Yes / No	$
			Yes / No	$
			Yes / No	$
			Yes / No	$
TOTAL FAMILY HOUSEHOLD INCOME (add the annual income of each household member together):				$

I certify that the information provided is accurate to the best of my knowledge, and that if I pay a discounted fee for today's visit, **I will provide the required documentation to IHC within 14 days** or by the time of my next visit, whichever is sooner**. If upon review IHC determines that I am NOT eligible for a discount or I fail to submit the required follow-up documentation, I agree that I am responsible for the non-discounted fee for today's visit.** I understand that I will be asked to update this information on annual basis. I understand I am fully responsible for my bill if I do not comply with the above requirements.

_____ _____ _____
Full Name (Print) Signature Today's Date

FOR OFFICIAL USE ONLY:
Patient Name:
Approved Discount:
Approved By:
Date Approved:
List the documents used to verify income. Please attach a copy of each.