Dear Patient/Applicant,

Alcona Health Center (AHC) is a non-profit, Federally Qualified Community Health Center with locations throughout northern Michigan. We offer comprehensive medical, behavioral health, dental and pharmacy services to everyone in the communities we serve using a Patient Centered Medical Home model of care. If you are concerned that you may not be able to pay for care you receive, you may be eligible for help through our sliding fee program whether you are insured, underinsured, or uninsured. Our sliding fee is available to patients below 200% of poverty level based on household income and family size.

AHC is sending you information on our sliding fee because you may have requested, or we believe it may assist you. Please complete the attached application with date and signature and return to your nearest clinic with the requested documents for consideration.

If approved the sliding fee will be granted for one year from your application. If you have prior visits you want to be considered for sliding fee, we do retro to prior dates of service going back one year from application approval. If you are applying for retro, income for the months you wish to go back too will need to be provided.

Along with the application: Please submit proof of income for all household members, include all sources of income being received.

Examples of proof of income:

- Minimum of two (2) recent paystubs (within the past 3 months) Figured on gross income.
- Social Security, SSI and/or Pension award letters
- Current Unemployment Check Stub or Notification/Approval
- Child Support Check Stub or award letter
- Approval/denial of eligibility for Medicaid (if applicable)
- Disability Award Notification letter
- Letters of support (should include date, amount per month they support with their information and signature)
- Others could include proof of: Veterans benefits, alimony, income from dividends, interest, rents, estates, and trusts.
- SELF EMPLOYED ONLY: Copies of your most recent tax returns (Federal 1040 or Schedule C)

We want to ensure those who qualify for sliding fee receive it and overall help our patients with rising out of pocket medical expenses. If you have any questions on the application or proofs of income required, we are here to help, please reach out to you providers office for assistance. If you need help finding or getting insurance coverage, AHC also helps with enrollment of insurances through Healthcare.gov, and Medicaid, speak your providers office for more information.

Sincerely,

Alcona Citizens for Health, Inc

Sliding Fee Application

The Alcona Health Centers is authorized by the Bureau of Primary Health Care to offer a Sliding payment scale, determined by family size and income, on the patient fees.

Those eligible for Medicaid and Medicare are to apply directly to those programs. AHC has Certified Application Counselors to assist you with this process.

NAME OF APPLICANT AND HOUSEHOLD MEMBERS YOU ARE FINANCIALLY RESPONSIBLE FOR:	Relationship to head of household	DATE OF BIRTH	Employment Status (Employed, Retired, Disabled, Student)
1. (Head of Household):			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ALL INCOME VERIFICATION and necessary documents MUST BE TURNED IN WITH THE APPLICATION. We MUST have proof of income BEFORE we process your application.

I UNDERSTAND ANY CHANGE IN INCOME MUST BE REPORTED WITHIN THIRTY (30) DAYS; and I attest that the above statements are true and correct to the best of my knowledge.

_____ _____

Signature **Date**

Current phone number: _____

For Staff use: **Print Name & Date Completed:**

CSS: Proper Income Documentation Received. Sliding Fee calculation worksheet completed. Scanned into Pending approval folder. **Signature and date completed.**	
Sliding fee approved dates and approved level range (AA, A, B C, F)	Level: Dates:
FAS- Completed application accurate, entered in to PM system, signature of approval	
FAS - Send patient Approval or denial letter, add to annual review reminder.	
Retro approval from Revenue cycle manager only	

Letter of Support

Patient Name: _____

Supporters name: _____

Relationship to patient: _____

The patient is receiving support due to little or no income from another person. List below how support is given examples include: Housing, groceries, bills, and/or cash support.

What is the total estimated support given monthly _____

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter: _____

Date: _____