Maniilaq Association

Sliding Fee Discount Program Application

Applicant Information

Full Name: ______________________________________ Date of Birth: ______________
Last *First* *M.I.*

Address: ____
Mailing Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Phone: ______________________ Email: ______________________

Total Household Members: ______________________

Please complete the following information for all household members, including yourself:

Full Name	Relationship to Applicant	Birth Date	Income Type*	Monthly	Total
	SELF				
				Total Income: *To be completed by staff*	

Documentation must be submitted within 30 days or before the next schedule appointment, whichever occurs first.

I certify that the above facts are true and correct to the best of my knowledge. I am aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination from the Sliding Fee Discount Program.

Patient Signature: ___________________________ Date: ________________

Parent/Guardian Signature: ___________________________ Date: ________________

STAFF USE ONLY

Discount Level: A☐ B☐ C☐ D☐

*Income Type Received

☐ Pay Stubs for a 4 week period	☐ Veteran's Payments
☐ Unemployment benefit statement or check	☐ Dividends
☐ Worker's Compensation	☐ Retirement Income
☐ SSA/SSI/APA Printout	☐ Other:
☐ Public Assistance	
Patient MRN:	Staff Initials:
Date Documentation Received:	

Please submit completed applications to PatientBilling@maniilaq.org