



## Welcome to our Patient Discount Program!

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**You'll need to provide the following documents to apply for the patient discount program:**

Checklist	
<b>Identification:</b> Driver's License, birth certificate, employment ID, social security card, or other	
<b>Income:</b> Prior year tax return (pgs 1 and 2) <u>or</u> W2 form, pay stubs for 1 month (if pay fluctuates, need pay stubs for 2 months), and other forms of income (e.g. Social Security, SSDI, Pension, TDI, Worker's Compensation, etc.)	
<b>Insurance:</b> Insurance card(s)	
<b>Medicaid:</b> Application made or evidence of rejection	

### **REMINDERS**

- To expedite processing of application, please be sure contact information is correct.
- You have **30 days** from the date you receive the application to submit the required documents.
- The minimum payment is \$10 for medical services, \$20 for behavioral health services, and \$30 for dental services. However, higher co-pays may apply to some dental procedures.
- Pharmacy discounts cannot be applied to prescriptions until applications have been approved. Molokai Drugs will not allow you to fill your prescriptions(s) on a pending or expired patient discount program.
- Patient discount program is valid for 12 months and must be renewed annually.

**SLIDING FEE SCALE (SFS) APPLICATION FORM**

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Section A – Application Information**

Date of Birth

Social Security #

Name: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Spouse's Name: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Patient Portal:**
☐ Yes ☐ No

 Phone: (Home) (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Marital Status: ☐ Single ☐ Married ☐ Separated

 (Work) (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Household Size: ☐ Cohab ☐ Divorced ☐ Domestic ☐ Widow Partnership

**Section B – Dependents** – List the names and birthdates of dependents (Children under 19, over 18 who are full-time students, adults whom you are sole support for). Use a separate sheet of paper if necessary.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Section C – Annual Household Income**

Source	Self	Spouse	Other	Total
Gross wages ( <i>income before taxes</i> ), salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, TDI, Social Security/Disability, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income				
Interest, dividends, gifts, rents, royalties, inheritance, income from estates, trusts, education assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
<b>Total Income</b>				

**Section D – Verification of Address and Income:** Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved. Please attach you and your spouse/legal domestic partner's, (if applicable) two most recent pay stubs, tax return or W-2. If not available, sign the authorization below so that we may request this information from your employer(s). We will also need to see your most recent utility bill (electric, water, telephone, or gas) or preprinted mail piece to verify your mailing address.

**SLIDING FEE SCALE (SFS) APPLICATION FORM****Authorization for Release of Information**

I authorize the release of information to the Molokai Community Health Center pertaining to my gross monthly / annual wages.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
Spouse/Legal Domestic Partner Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**Section E – Personal Statement**

I hereby certify that the above information is true and correct to the best of my knowledge. If eligible for the sliding fee scale, I understand that the discount will be applied after insurance plan coverage. The maximum I will pay is the amount an eligible patient in my discount level would pay regardless of insurance status. I further understand that this discount only covers services that can be performed by Molokai Community Health Center. I also agree to notify the Molokai Community Health Center within ten (10) days of any changes in information provided in this application, and understand that I must reapply for the sliding fee scale (within ☐ 2-weeks or every ☐ 12 months) or my account will reconvert to 100 percent pay status.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**OFFICE USE ONLY**

Patient Name: \_\_\_\_\_

Approved Sliding Fee Scale: ☐ Conditional 2-Week ☐ 12 Months

Household Size: \_\_\_\_\_ Monthly / Annual Income: \$ \_\_\_\_\_

Approved Discount: ☐ A 100% ☐ B 80% ☐ C 60% ☐ D 40% ☐ E 20% ☐ Denied 0%  
(Check One)

Expires On: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Revised Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Verification Checklist	Yes	No
Identification/ Address Verification: Driver's license, State ID, Passport, employment ID, Utility bill, or other		
Income: Prior year tax return, two most recent pay stubs, or other		
Insurance: Current Insurance Cards (not used for SFS Discount calculation)		

Approved by:

\_\_\_\_\_  
Front Desk staff Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
CFO Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**Nominal Fees and effective dates below:**

Labs	\$ 45.00	Effective 2019
Primary Care	\$ 10.00	Effective 2019
Behavioral Health Services	\$ 20.00	Effective 2019
Dental – Preventative, Basic & Urgent	\$ 30.00	Effective 2019