Maui's Native Hawaiian Health Care System

Office Use Only	
Discount Fee Category	________
Verified by	________
Letter mailed	________

SLIDING FEE DISCOUNT APPLICATION

(Upon approval, discount available for one year from date of approval)

PATIENT INFORMATION

Patient Name: ____

Last First MI

Address: ____

Street City State Zip Code

Phone Number: ____

Home Cell Work/Other

FAMILY INFORMATION

Please list your family members.

The definition of family for this application is all family members who are listed on your annual tax return.

This application will be used to verify income for all listed family members.

1.____ Y/N circle one

Name Relationship Hui Client

2.____ Y/N

Name Relationship Hui Client

3.____ Y/N

Name Relationship Hui Client

4.____ Y/N

Name Relationship Hui Client

5.____ Y/N

Name Relationship Hui Client

Please attach additional sheet if necessary

FAMILY INCOME

All sources of income for the family members listed above

Total Family Income________________________________ per **month/year** (circle one)

Please attach one of the following proof of income documents:

- -Most recent Federal tax returns (Page 1 & 2 and supporting schedules)
- -Most recent consecutive pay stubs (at least 2)
- -Social Security benefit letter
- -Pension documents
- -Worker's compensation documents
- -Unemployment
- -Temporary disability
- -Bank statement

****For individual's without any of the above income documents, please fill out the supplemental income section**

SUPPLEMENTAL INCOME FORM

Only fill out if you have not provided proof of income documents

Housing:

a. I receive HUD assistance (please attach letter/document)
b. I live with relatives/others and did not pay rent _______(initial)
c. I work in exchange for rent. My monthly rent was equivalent to $__________ for the year

Food:

I receive food stamps (please attach letter/document)

Medical:

I receive MedQUEST (please attach card/letter/document)

By providing documentation of benefits from HUD, MedQUEST or food stamps, you will be qualified for a discount.

ACKNOWLEDGEMENT

I am providing Hui No Ke Ola Pono Inc. with a list of all of my family members and all income information to apply for a sliding fee discount under the federal regulations set forth by the Native Hawaiian Health Care Improvement Act. I acknowledge that this information is accurate and complete. I will immediately report any change in financial status or the number of people in my household by completing a new application. I understand that the information provided will be reviewed **annually** with the possibility of discount percentage changes as determined by the Federal Poverty Level publication. I further understand any falsifications or the failure to report any changes may result in ineligibility for the discount and may be considered perjury.

Signature Date

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Family Size ________________________ Family Income _______________________________ per (month/year)

Documents received:

___Most recent Federal tax returns (Page 1 & 2 and supporting schedules)
___Most recent consecutive pay stubs (at least 2)
___Social Security benefit letter
___Pension documents
___Worker's compensation documents
___Unemployment
___Temporary disability
___Bank statement

I attest that all documents have been received and reviewed for determination of sliding fee discount. Falsification of information or failure to report any changes will result in disciplinary action and may result in termination.

Staff Signature Date