Maui’s Native Hawaiian Health Care System

SLIDING FEE DISCOUNT APPLICATION
(Upon approval, discount available for one year from date of approval)

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>__________________________________________</th>
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<td>Last</td>
<td>First</td>
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<tr>
<td>Address:</td>
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<td>Street</td>
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<tr>
<td>Phone Number:</td>
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**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.

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Relationship</th>
<th>Hui Client</th>
<th>Y/N</th>
<th>circle one</th>
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**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.

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**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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**FOR OFFICE USE ONLY**

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

Documents received:  
  ____Most recent Federal tax returns (Page 1 & 2 and supporting schedules)  
  ____Worker’s compensation documents  
  ____Most recent consecutive pay stubs (at least 2)  
  ____Unemployment  
  ____Social Security benefit letter  
  ____Temporary disability  
  ____Pension documents  
  ____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 ___________