Wahiawā
Center for Community
Health

VERIFICATION REQUEST FORM

FOR STAFF USE ONLY

Please indicate the Service and Verification Dates here and give it to the Applicant for their convenient reference.

Service Date: ________________

Verification Due: ______________

Dear Applicant,

Before we can process your Sliding Fee Discount Application, we need proof of your income. The documents listed below are acceptable:

- Pay stubs for the last month
- Veterans benefits;
- General assistance;
- Worker's compensation;
- W-2 forms;
- Pension notice;
- Previous year's federal income tax return;
- Social Security income verifications;
- Alimony/Child support;
- Unemployment or disability income verification;
- Stipends, gifts, and donations.

If you are self-employed, a copy of your tax return with Schedule C, or copies of invoices to your clients for the past 3 months plus deposit and business expense records are sufficient.

Copies of any of the above noted documents will help us determine your eligibility.

To receive discounts under this program, you must return the requested documents to Wahiawa Health within 14 days from the date of service. If you fail to submit these documents, YOU WILL BE RESPONSIBLE FOR PAYING THE ENTIRE COST OF THE VISIT. Patient will notified if they are approved and will be required to renew the application within one year of approval date.

If a patient declines to provide family size and/or income information, he or she will not be eligible for a discount, and the application will be denied. The Finance office will place a note in the patient's account indicating that the patient's application was denied, and that the patient is ineligible to re-apply.

Please contact Wahiawa Health if you have any questions regarding the Sliding Fee Discount Program at (808) 622-1618 option 2 to be transferred to our Community Health Worker or Patient Advocate.

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SLIDING FEE DISCOUNT APPLICATION

Please complete this form as accurately as possible to help you qualify for Sliding Fee discounts. Your personally identifiable information is never reported to, or shared with, anyone else. ***If you would like help applying for health insurance, please notify the Front Desk that you'd like to see our Community Health/Patient Advocate Staff***

APPLICANT INFORMATION

Last Name: ______________________ First Name: ______________________ MI: ________

Mailing Address: ______________________________ City: ______________ Zip: ________

Residence Address: ______________________________ City: ______________ Zip: ________

Phone: ________________ Work Phone: __________Married/Single/Divorced/Widow__________

Email Address: ____________________________________Date of Birth: ______________

Do you live in: ☐ Public Housing ☐ Transitional Housing ☐ Homeless Shelter ☐ On the street ☐ Other: __________

Are you disabled? ☐ Yes ☐ No **Are you a Farmworker?** ☐ Yes ☐ No ☐ Seasonal ☐ Migrant

Are you a Veteran? ☐ Yes ☐ No *If "Yes," have you been discharged?* ☐ Yes ☐ No Discharge Date: __________

Refugee Status: ☐ Yes ☐ No *If "Yes," what is your country of origin?* ______________________

HOUSEHOLD MEMBERS

How many people live in your household? ________ ***Please list all who live in your household below.***

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

Name: ____________________ DOB: __________ Relationship: __________ Pays Expenses? Yes No

INCOME SOURCES	**Annual Income *or***	**Monthly Gross**
Employer Name (Applicant): ______________________	$ ________	$ ________
Employer Name (Spouse): ______________________	$ ________	$ ________
Unearned Income Source (e.g., SS, SSDI, TDI, pension): ______________________	$ ________	$ ________
If self-employed, Business Name: ______________________	$ ________	$ ________
Other Income Source: ______________________	$ ________	$ ________
Other Income Source: ______________________	$ ________	$ ________
Other Income Source: ______________________	$ ________	$ ________

Proof of income is required to process your application. A copy of your most recent federal income tax return is preferred as proof of income, however, the documents listed below are also acceptable:

- Pay stubs for the last three pay periods;
- Veterans benefits;
- General assistance;
- Worker's compensation;
- Alimony/Child support;
- Unemployment of disability income verification;
- W-2 forms;
- Pension notice;
- Previous year's federal income tax return w/Schedule B;
- Social Security income verifications;
- Previous year's federal income tax return w/Schedule C;
- Stipends, gifts, and donations.

Please complete this Income Declaration only if you do not have any income, or are unable to provide proof of your income.

INCOME DECLARATION

Please explain why you are unable to provide proof of income. For example, you may be paid only in cash, and do not have a bank account; or you take care of your relatives' children, or elderly parents, in exchange for living in their home.

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____

Please describe your financial situation to explain how you are able to meet your needs for food, housing, and transportation.

____

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SLIDING FEE DISCOUNT APPLICATION

I, ____ ,
Print Applicant's Full Name

DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF HAWAIʻI THAT I HAVE ACCURATELY REPORTED AND DOCUMENTED MY INCOME, OR LACK THEREOF, TO THE BEST OF MY ABILITY.

__________ Initials	**I UNDERSTAND THAT A FALSE DECLARATION OF INCOME WILL RESULT IN PERMANENT WITHDRAWAL OF MY ELIGIBILITY TO PARTICIPATE IN THE SLIDING FEE DISCOUNT PROGRAM.**
__________ Initials	**I UNDERSTAND THAT THIS SLIDING FEE DISCOUNT PROGRAM APPLIES ONLY TO SERVICES PROVIDED BY HAWAI ʻI ISLAND COMMUNITY HEALTH CENTER.**
__________ Initials	**I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE FULL COST OF ANY SERVICES RECEIVED UNLESS APPROVED FOR THE SLIDING FEE DISCOUNT.**

____ __________________________________
Signature of Applicant Date

This notice contains CONFIDENTIAL information intended only for the use of Wahiawa Center for Community Health. Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence. If you are NOT the intended recipient of this information, or an agent or employee responsible for delivering it to the intended recipient, you are hereby notified that any unauthorized dissemination or copying of this notice, or the information contained herein, is strictly prohibited.

FOR STAFF USE ONLY

APPROVED BY______________________________ DATE ____________________________

SLIDING SCALE FEE ___________________________

EXPIRATION DATE ____________________________

DATE SCANNED INTO CHART _________________

DATE COPY GIVEN TO PATIENT_________________

NO PROOF OF INCOME WORKSHEET

PATIENT INFORMATION

Last Name: ______________________________ First Name: ___________________________ DOB:_________

Mailing Address: ____ City: __________________ Zip: _________

Residence Address: ______________________________________ City: __________________ Zip: _________

Home Phone: ___________________ Cell Phone: _____________________

HAVE YOU APPLIED FOR MEDICARE, MEDICAID, PRIMARY CARE NETWORK (PCN) OR CHILDRENS HEALTH INSURANCE PROGRAM (CHIP) ? CIRCLE: YES NO IF YES, CIRCLE: MEDICARE MEDICAID PCN CHIP

Please Provide the following information for the person who provides financial support to applicant.

Last Name: ______________________________ First Name: ___________________________ MI: __________

Mailing Address: ____ City: __________________ Zip: _________

Home Phone: ____

The person listed above must provide the following information:

1. How long has the applicant been living with you? __________ YEAR(S) ________ MONTH (S)

2. How much financial support did you provide last month? (i.e. rent, utilities, food etc.) Please provide brief description:

I certify that the information given on this form is complete, true, and correct.

____ ____________________________________
Signature of Applicant Date

____ ____________________________________
Signature of Financial Supporter Date