Wahiawā 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 be notified if they are approved or denied. If approved, you will be required to renew the application within one year of approval date.

If you decline to provide family size and/or income information, you or your family member will not be eligible for any discount, and the application will be denied. The Finance office will place a note in the account indicating that the application was denied, and that the patient is ineligible.

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.

Wahiawā Center for Community Health

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: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Date of Birth: _____

HOUSEHOLD MEMBERS

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

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Wahiawā Health

SLIDING FEE DISCOUNT APPLICATION

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
- Veteran's 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.

Wahiawā Health

SLIDING FEE DISCOUNT APPLICATION

I, _____ ,
Print Applicant's Full Name

DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF HAWAI'I 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 WAHIAWA HEALTH AND WAIALUA 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: _____

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: _____

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

_____ _____

Signature of Applicant Date

_____ _____

Signature of Financial Supporter Date