Maniilaq Health Services

Financial Assistance Application

If your income is at or below the federal poverty guidelines, you may qualify for a discount on the cost of your medical care. Maniilaq Health Services has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient ability to pay. If no insurance is available, screening for Alaska Medicaid is encouraged but no required.

2025 ALASKA Poverty Guidelines

Maniilaq Portion	100%	75%	50%	25%	0%
Patient Portion	**0**	**charge = 25%**	**charge = 50%**	**charge = 75%**	**charge = 100%**
Family Size	100%	150%	175%	200%	Above 200%
1	$19,550	$29,325	$34,213	$39,100	$0
2	$26,430	$39,645	$46,253	$52,860	$0
3	$33,310	$49,965	$58,293	$66,620	$0
4	$40,190	$60,285	$70,333	$80,380	$0
5	$47,040	$70,560	$82,320	$94,080	$0
6	$53,950	$80,925	$94,413	$107,900	$0
7	$60,830	$91,245	$106,453	$121,660	$0
8	$67,710	$101,565	$118,493	$135,420	$0

Families/household with more than 8 persons, add $6880 for each additional person

Why do we need to know your household income?

- Some of our program budget comes from grant money. For most of these grants, income information from our patients is necessary to prove financial need in the communities we serve.
- These grants allow us to provide a much higher level of quality and greater availability of care than we could otherwise serve.
- In order to obtain these grants and to keep them, we need to provide demographic information, including financial resources of patients to prove that we are serving the people that grant money has been set aside for.

If you have any questions about sliding fee discounts, please contact the Patient Financial Services Department at Maniilaq. Email: PatientFinancialServices@maniilaq.org PH# 907-442-7238

I have been advised that I must return this application to the clinic within fifteen (15) days to receive a discount and if I do not do so by the expiration date, I will be required to pay 100% of the fee. I understand that the sliding fee discount does not apply to medications; eye clinic visits and equipment; hearing aids; and dental hardware, or services provided at the clinic by independent specialists or service providers. The sliding fee discount is a resource of last resort. Services will not be denied based on ability to pay**.**

Grace Period Expires On: ____________________ MRM#____________________

______________________________ ______________________________ __________

Patient Name Applicant Signature Date

Maniilaq Health Services

Eligibility Determination for Sliding Fee Discounts

Name of Applicant: ______________________________ Birth Date: __________ MRM: __________

Are you covered by any of the following forms of insurance?

a)	Private Insurance	No	________	Yes	____________
b)	Medicare	No	________	Yes	____________
c)	Medicaid	No	________	Yes	____________
d)	Marketplace Insurance	No	________	Yes	____________

List all other household members by name, birthday, age, and family relationship:

Name:	DOB:	Age:	Relationship to Applicant:

List all sources of income for each household member. Income is defined as cash receipts received from all sources before taxes. Wages, Alimony, Child Support, Foster Care, Unemployment, ATAP Cash, Workers Compensation, Social Security, Longevity Bonus, Retirement Bonus, Disability, Interest/Dividends, Rental Income, and any other income.

Amount:	Pay frequency:	Employer or Source of Income:	Paid to:
$			
$			
$			
$			
$			
$			
$			

The information I have provided concerning the size of my household/family and my household/family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge.

I have given this information concerning my financial situation and my means and ability to pay for the purpose of procuring discounts to my own and my household/family's accounts with Maniilaq Health Services (MHS). I understand that MHS will rely on such information to determine applicable discount rate for my account.

I agree to report any change in either my income or my family size to MHS before or at the time of my next contact or any contact by any family member with MHS. I know that the information I have given will continue to be relied upon until it is changed.

My signature below indicates that all information I have provided is true to the best of my knowledge.

______________________________ ______________________

Signature (Applicant/Head of Household) Date