



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