MĀLAMA I KE OLA
HEALTH CENTER

Sliding Fee Discount Program Application

NOTE: We are required by law to collect income data on all patients. In addition, you may qualify for a discount on our services so it is necessary to ask the following questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year in order to continue to receive discounts. Your most recent federal tax return, a copy of your most recent paycheck stubs, copies of your Social Security/Unemployment/Retirement benefit letters, letter from your employer, bank statement or other income will be sufficient proof.

First Name:	**Middle:**	**Last**:			**Other names:**
Home Address:	**City:**	**State:**	**Zip:**	**HI Resident?** ☐ **Y** ☐ **N**	**Have you applied for medical assistance?** ☐ **Y** ☐ **N**
Phone:	**Date of Birth:**	**Are you homeless?** ☐ **Y** ☐ **N**		**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **In a Relationship**	

Household Members	**NAME**	**Date of Birth** (MM/DD/YYYY)	**Health Insurance**	**Relationship**	**Patient at Mālama I Ke Ola Health Center?**

	Monthly/Annual Income	**For YOU**	**For SPOUSE**	**For Children**	**For Other**	**Subtotal**
Income	Gross wages, salary and tips					
	Social Security & pensions					
	Annuity & veteran benefits					
	Child support & alimony					
	Self employment & other					
					TOTAL	

QUEST Application	
Provided	/ /
Received	/ /
☐ **Ineligible**	☐ **Refused**

Completed Discount Application	
Effective Date	/ /
Expiration Date	/ /
Authorized by:	

I verify that all information provided on this form is true and correct to the best of my knowledge. Fraudulent self-reporting on any portion of this application may jeopardize your status at Mālama I Ke Ola Health Center and/or may be punishable by law.

SIGNATURE:_____ DATE:_____

NAME PRINTED:_____ INTERPRETER NAME:_____

Implemented:	
Reviewed:	
Revised:	