Cordova Community
MEDICAL CENTER

P: (907) 424-8000 | F: (907) 424-8116
P.O. Box 160 | 602 Chase Ave., Cordova, AK 99574-0160

Sliding Fee Scale/Discounted Fee Information

The information you provide is confidential. We use it only to evaluate if you are eligible for a discount.

How does the program work?
We will not deny you necessary care due to an inability to pay at the time of service. If you have insurance or other medical benefits such as Medicare, Medicaid, Indian Health Services, commercial payer, or the Veteran's Administration please inform us on the application, they will be billed first. If you do not have insurance, or if your insurance does not cover the full cost of service, the remaining portion is considered patient responsibility.

You should receive an explanation of benefits (EOB) from your insurance company with this information. You will also receive a statement from CCMC for the services you received. When you receive your bill from CCMC, we may be able to help you reduce your patient responsibility with our sliding fee scale.

In order to be considered for our sliding fee scale, CCMC is required to gather various patient financial information, which is accomplished through the Sliding Fee Scale/Discounted Fees application. This information is gathered in order to comply with Federal requirements to write off patient balances.

Eligibility for a discount at CCMC is based upon a family's financial standing in relation to the federal guidelines.

What happens if I am approved for the Sliding Fee Scale or Discounted Rates?
If we approve your request for our sliding fee scale or discounted rates, we calculate the discount as a percentage of the total you owe. We apply the discount on amounts remaining after insurance has been billed. In order to ensure accuracy, please keep us updated on your medical benefits, if any.

Why do I need to re-apply every six months?
Financial situations change, so we ask that you re-apply every six months to ensure we have current medical benefit and financial information. Before you reapply, we encourage you to contact the Patient Account Specialist at 907-424-8227, to see what paperwork is needed. In some cases, we may only require that you send updated paperwork that we can attach to a previously filed application, rather than a new application.

CCMC will charge you a nominal fee.
CCMC requires that patients who are otherwise eligible for a 100% discount pay a nominal fee of $20.00 per visit with a medical provider or approved laboratory, radiology, rehab, or mental health services.

What charges cannot be considered for a discount (excluded charges)?
CCMC's Sliding Fee Sale/Discounted Fees policy only applies to medically necessary services as determined by a medical provider.

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Sliding Fee Scale / Discounted Fees Application

CCMC's policy is to provide medically necessary services regardless of a patient's ability to pay. Discounts are offered based upon household income. Please fill in the following areas and return this form and copies of information listed on the verification checklist to CCMC. Our staff will review your application to determine your sliding fee discount based upon the information submitted below.

Applicant Information

Name		Date of Service		Amount Owed
Street/PO Box	City	State	Zip	Phone

Household Information: Please complete the following for the head of household, spouse, adult children or adult dependents, and dependent children under the age of 18 living in the patient's household.

Name	Date of Birth	Relationship to Applicant	Place of Employment	Is The Job Seasonal?

Household Assets: Please complete the following for yourself, your spouse, and your adult dependents.

Financial Assets	Head of Household	Spouse	Total
Amount in Checking/Savings Accounts			
Other Liquid Assets (please explain)			
Total Value of Assets			

Monthly Household Income

Please complete the following for you, your spouse, and your adult dependents.

Incomes	Self	Spouse	Total
Gross wages, salaries, tips, etc.			
Social Security, pension, annuity, veteran's benefits, public assistance, unemployment			
Alimony, child support, foster care, military family allowances and allotments			
Self-Employed Income			
Rent, interest, dividend and other income			
Worker's Comp, Disability			
Other income (please explain)			
Total Income			

Monthly Financial Obligations

Please indicate any monthly financial obligations such as housing, transportation, child care, etc.

Expenses	Self	Spouse	Total
Mortgage/Rent:			
Insurances (Car, Life, etc.):			
Alimony /child support:			
Car Payment:			
Utilities:			
Phone:			
Other:			
Total Expenses			

Access to Medical Benefits

Check all that apply for each member of your household.

Insurance or Benefit Eligibility	Self	Spouse	Dependents	Total
Third Party Insurance Plan(s)				
Tricare				
Medicaid				
Medicare				
Native Benefits				
Veterans Benefits				

Applicant Certification (or Parent/Legal Guardian if Applicant is a minor):
I certify that the information provided is correct and that I have fully disclosed all requested information.

Signature_____

Printed Name_____Date _____

Verification Checklist

Attach copies of items listed below for each household member	**Submitted for Review?**	
	YES	NO
Identification (*any one of these items from the following list*): Driver's license, state ID card, birth certificate, employment ID, passport, social security card		
Income: Prior year tax return, three most recent pay stubs		
Insurance/Medical Benefits: Insurance card(s)		
Medicaid Application in Process?		

CCMC Financial Services Review and Approval.

Reviewed by: Date:

Visit/Claim Number: SFS Discount %:

Approval:

Notes: