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.

Will CCMC charge 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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FINANCIAL ASSISTANCE APPLICATION

This is an application for financial assistance at Cordova Community Medical Center. Financial assistance is for people that meet certain income requirements. You may qualify for financial assistance even if you have health insurance coverage. Assistance is determined based on the Federal Poverty Guidelines for Alaska. CCMC's policy is to provide medically necessary services regardless of a patient's ability to pay. Our staff will review your application to determine your sliding fee discount based upon the information submitted below.

For your application to be processed, you *must* provide the following information as well as documentation that verifies your income your identity.

PATIENT AND APPLICANT INFORMATION

Patient Full Name (First, Middle, Last): _____

Patient Date of Birth: _____

Person Responsible for Paying the Bill (Guarantor): _____

Guarantor's Relationship to the Patient: _____

Guarantor's Date of Birth: _____

Mailing Address:

_____

_____

_____ _____ _____

City State Zip

Contact Information:

Home Phone: _____

Cell Phone: _____

Email: _____

Current Employment Status of Guarantor

Employer: _____ Employed Since: _____

Unemployed? Yes ☐ Since: _____ Self Employed? Yes ☐ Since: _____

Retired? Yes ☐ Since: _____ Student: Yes ☐

Disabled: Yes ☐ Other: _____

HOUSEHOLD INFORMATION

Household Information: Please list all family members in your household, including yourself. All income must be disclosed. Sources of income include wages, unemployment, self-employment, workers compensation, disability, social security income, child/spousal support, work study, pension, retirement account distributions, etc.

Household Member 1

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Wages per Month: _____ Other Income: _____

Total Gross Monthly Income: _____

Also Applying for Financial Assistance? Yes: ☐ No: ☐

Household Member 2

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Wages per Month: _____ Other Income: _____

Total Gross Monthly Income: _____

Also Applying for Financial Assistance? Yes: ☐ No: ☐

Dependent Information

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	ALSO APPLYING FOR FINANCIAL ASSISTANCE?

You must provide information on your family's income. Income verification is required to determine financial assistance. Please provide the following documents for verification of income:

- Most recent W-2(s)
- Last two months of pay stubs
- Most current income tax return with W-2's
- Written, signed statements from employers of others stating your current financial situation and circumstances if you have no proof of income

ADDITIONAL INFORMATION

Please let us know if there is any additional information about your current financial situation that you would like us to know, such as financial hardship, seasonal or temporary income, or personal loss. You can also give us a brief description of your financial situation and include any nondiscretionary spending obligations that you have (things like medical bills, housing cost, child support obligation), and any future known medical needs here:

ACCESS TO MEDICAL BENEFITS

Check all that apply for each member of your household:

INSURANCE OF BENEFIT ELIGIBILITY	SELF	SPOUSE	DEPENDENTS
Third Party Insurance Plan(s)			
Tricare			
Medicaid			
Medicare			
Native Benefits			
Veterans Benefits			

PATIENT AGREEMENT

By signing below, I certify that the information provided is true and accurate to the best of my knowledge. I understand that CCMC may verify the information provided. If the information I gave is determined to be false, the result will be denial of financial assistance and I will be responsible for and expected to pay for the services provided.

_____ _____

Guarantor Signature Date

CCMC REVIEW AND APPROVAL INFORMATION

Reviewed by: Date:

Sliding Scale Determination: Dates Approved For:

Visit/Claim Number(s) to Adjust: Total to be Adjusted:

_____ _____

Director of Finance Signature Date