IMPORTANTREMINDERS

- ✓ You must complete a "Sliding Fee Discount" Application and bring proof of income.
- ✓ The Sliding Fee Program does not cover services prior to the date your application is approved.
- ✓ You MUST renew your discount application every year. You must report any changes to your income or insurance eligibility.
- ✓ This discount program is only good at the Northern and Southern Community Health Care Centers. You cannot use this at other clinics or hospitals.
- ✓ This is ***NOT*** an insurance program. We only give a discount on services covered under the program.
- ✓ If you become eligible for insurance, you ***MUST*** surrender your Sliding Fee Discount Card.

CONTACT INFORMATION

Northern Region Community Health Center

Screening Nurse
671-635-7400

Appointment Scheduling
671-635-7400
671-635-4410

Pharmacy (Northern)
Business Hours
Monday, Tuesday, Thursday
9am – 5pm
Friday
9am – 12pm
Phone #: 671-635-4406

Southern Region Community Health Center

Appointment Hotline
671-828-7604

Medical Records
671-828-7511

Pharmacy (Southern)
Business Hours
Wednesday
9am – 5pm
671-828-7567

Bureau of Primary Care Services Northern and Southern Community Health Care Centers

Sliding Fee Scale Discount Program

"The mission of the Bureau of Primary Care Services is to improve the health status of the people of Guam and provide leadership in health information and surveillance, assurance of a healthful environment, and promotion of community partnerships."

What is the Sliding Fee Discount Program?

The Sliding Fee Discount Program provides a lower cost for medical services given within the Northern and Southern Community Health Centers only.

Who can apply for the Sliding Fee Discount Program?

Anyone can apply for the "Sliding Fee" discount program.

What is required to apply?

There are several simple steps to applying for the "Sliding Fee" discount program.

- Pickup and complete a Sliding Fee application from the Northern or Southern Community Health Care Centers.
- Bring a copy of the following documents:
  - Photo I.D's for all adult members
  - Proof of income for one month or statement of support.

What is covered under the discount program?

The "Sliding Fee" discount program only covers services provided at the Northern and Southern Community Health Care Centers. Services may include:

- Child health, immunizations, early periodic screening and diagnostic testing for children, fluoride varnish treatment, women, infants, and children services, vision screening
- Cancer screening, communicable disease control, chronic disease control,
- Sexually transmitted disease screening and treatment (STD/HIV counseling and treatment)
- Mental health and substance abuse counseling, health education services, and
- In-house pharmacy services.

Discounts are not applicable services offered outside of the Northern and Southern Community Health Centers.

Sources of Income (Earned or Unearned)

- Wages, salaries, and tips
- Self-employment Income
- Workmen's compensation
- Welfare benefits
- Social Security benefits
- Pensions
- Veteran's benefits
- Survivor benefits
- Money given from friends or family members.

Any other earned or unearned income not included in this list.

Proof of Income

Proof of income is required to qualify for the discount program and includes the following:

- Most recent check stubs for one month.
- An employment verification from employer showing average hours per week, hourly rate, and average over-time hours earned.
- Details for the months of income expenses for the business for self-employed individuals.

If the applicant is unemployed you must submit a statement of support showing the average amount of money given from family or friends per month.

**************************************CONFIDENTIAL***

NORTHERN/SOUTHERN REGION COMMUNITY HEALTH CENTER "SLIDING FEE DISCOUNT" APPLICATION

For Official Use Only:

Submission Date:____________

Verification Date:_____________

EHR/CHART #:______________

SECTION A – APPLICANT INFORMATION

APPLICANT NAME:	DATE OF BIRTH:
CO-APPLICANT NAME: (SPOUSE/COMMON LAW)	DATE OF BIRTH:

CURRENT MAILING ADDRESS:

CURRENT PHYSICAL ADDRESS:

MARITAL STATUS: (CHECK MARK ☑WHICH APPLIES TO YOU/APPLICANT	SINGLE:☐ MARRIED:☐ WIDOW ☐ DIVORCE/SEPARATED:☐ COMMONLAW (CL):☐

SECTION B – FAMILY FINANCIAL STATUS

	APPLICANT	SPOUSE
OCCUPATION		
EMPLOYER		
ANNUAL GROSS SALARY	$	$

OTHER SOURCES OF INCOME:
(FOR APPLICANT, SPOUSE, AND DEPENDANT FAMILY MEMBER(S)

SOURCE	TOTAL AMOUNT
STATE SUPPLEMENTARY PAYMENTS	$
RETIREMENT, DISABILITY, WORKERS COMPENSATION, SOCIAL SECURITY , UNEMPLOYMENT, COMPENSATION	$
ALIMONY, CHILD SUPPORT	$
DIVIDENDS, INTEREST, GIFT, INHERITANCE	$
TOTAL SALARY AND OTHER SOURCES OF INCOME	$

SECTION C – DEPENDENTS

LIST THE NAME(S), DATE OF BIRTH, AND AGE(S) OF YOUR DEPENDENT(S)*.
*CHILD (REN) UNDER 18 YEARS OLD ONLY. CHILD (REN) 18 YEARS OF AGE AND OLDER CAN APPLY SEPARATELY.

NAME:	DATE OF BIRTH: / /	AGE:
NAME:	DATE OF BIRTH: / /	AGE:
NAME:	DATE OF BIRTH: / /	AGE:
NAME:	DATE OF BIRTH: / /	AGE:
NAME:	DATE OF BIRTH: / /	AGE:

SECTION D – PERSONAL STATEMENT

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF ELIGIBLE FOR THE SLIDING DISCOUNT PROGRAM, I UNDERSTAND THAT THE DISCOUNT WILL BE APPLIED TO THE PORTION OF MY BILL THAT IS NOT COVERED BY MY HEALTH PLAN. I ALSO AGREE TO NOTIFY THE NORTHERN/SOUTHERN REGION COMMUNITY HEALTH CENTER WITHIN FIVE (5) WORKING DAYS OF ANYCHANGE IN MY INCOME STATUS TO REASSESS MY ELIGIBILITY FOR THE SLIDING FEE SCALE PROGRAM. I HAVE BEEN NOTIFIED THAT I MUST COMPLETE AND UPDATE A SLIDING FEE APPLICATION ANNUALLY (ONE YEAR FROM MY APPROVED APPLICATION DATE) SO THAT ELIGIBILITY CAN BE DETERMINED ON THE FAMILYSIZE AND INCOME BASED ON THE FEDERAL INCOME POVERTY GUIDELINES.

____________________________ ____________________

APPLICANT SIGNAURE DATE

SLIDING FEE DOCUMENTATION NEEDED UPON SUBMISSION OF APPLICATION

This is a Discount Program. Please provide the following:

1. Photo Identification of Applicant and Spouse if applying as Married or Common-law (e.g. Driver's License, Guam I.D., any valid Passport).
2. Birth Certificates (all household members listed on Section A and Section C). However, if a birth certificate is unavailable, it may be substituted for any valid passport, or government identification card. A driver's license is acceptable as another form of identification.
3. Check Stubs – One month's worth for all working member(s) in the family and any other documents of financial income (e.g. prior year W-2 form, social security, alimony, and child support). **If applicant has No Financial Income**, we need a letter of living arrangement from whoever is giving financial support to the applicant(s). If there is no proof of income (i.e., check stubs), the applicant must submit a **"Self-Declaration of Income"** (applicable for the homeless and unemployed)
4. Current Contact Number(s): Please ensure that all home, cell and other numbers are currently working so that an Eligibility Specialist can contact you regarding your application status approval or disapproval.

Home: ________________ Cell: ________________ Other: ________________

Note: **All documents must be copied** and turned in with the application in order for it to be processed. **Any incomplete applications will delay the application process**. Any child(ren) 18 years or older can apply separately. If you have any questions please contact an Eligibility Specialist at 632-0707(NRCHC) or 828-7501 (SRCHC).

FOR INTERNAL USE ONLY

APPLICANT AND FAMILY MEMBERS APPLYING FOR THE SLIDING FEE DISCOUNT PROGRAM ARE:

☐ **APPROVED**

- ☐ 100%
- ☐ 75%
- ☐ 50%
- ☐ 25%
- ☐ 10%

☐ **DISAPPROVED** REASON(S) FOR DISAPPROVAL:

- ☐ LACK OF HOUSEHOLD INCOME VERIFICATION FROM FAMILY MEMBER(S) SUPPORTING THE APPLICANT
- ☐ INCOMPLETE APPLICATION (MISSING DEMOGRAPHIC/SOCIO-ECONOMIC DATA ON THE APPLICATION)
- ☐ LACK OF SUPPORTING DOCUMENTATION (MISSING BIRTH CERTIFICATE, EMPLOYMENT CHECK STUBS, RESIDENCY VERIFICATION)
- ☐ INCOME EXCEEDS 200% OF FEDERAL INCOME POVERTY GUIDELINE

APPLICANT WAS CALLED ON: ____/____/____ by the

____

CHC CHIEF EXECUTIVE OFFICER DATE

- ☐ ELIGIBILITY SPECIALIST
- ☐ CASHIER
- ☐ MEDICAL RECORDS CLERK
- ☐ OTHER SPECIFY: ________________

CHC Staff Signature: ________________

Date: ________________