SLIDING FEE DISCOUNT PROGRAM APPLICATION

Date	
Patient Name	
Address	
Phone Number	

Bethel Family Clinic (BFC) defines a household as all individuals residing in the same home and sharing expenses. Household members include the patient, spouse, significant other, grandparents, children, foster children, and other dependents. Please list yourself and all members of your household you wish to include in your household size.

BFC uses your gross income to determine eligibility for discounted services. The following documentation is required for eligibility.

- Adult Identification: Driver's License, passport, passport card (picture ID), State identification card, birth certificate, marriage license (if name verification is needed). employment identification badge, public aid identification card, matricula card, utility bill, and voter's identification card.
- Minor identification: may include birth certificate, identification card and/or social security card
- Income: (Please ask BFC Staff if you have any questions)
  - Paycheck stubs with year-to-date information (For last 45 day/three pay period cycles) and/or
  - Most recent tax returns and/or
  - Bank statements and/or
  - Statement of income determinations from Federal, State or Award Letter-Veteran Affairs, Social Security, Child Support, Unemployment, Supplemental Security Income, Workers Compensation, Public Assistance, and Local government and/or.
  - BFC's No Proof of Income Worksheet (Next Page)

First and Last Name: (Individuals that live in your home)

	Age	Relationship to Patient	Monthly Income
		Self	$
			$
			$
			$
			$
			$
			$
			$
		Total Household Income	**$**

I certify that the information given on this form and the provided income documentation is complete, true and correct. If I do not qualify for financial assistance, I agree to pay the outstanding balance in full or set up payment arrangements. I agree and understand that any remaining balance not paid through resulting collection charges, legal fees, and understand that access to Bethel Family Clinic services may be restricted. I understand that the financial assistance will expire one year or twelve (12) months on or before the date indicated below and I will be required to reapply. If there is a change in income, I will submit a new Sliding Fee Discount Program Application. You will receive a letter in the mail stating eligibility.

Signature: ____ Date: __________________

NO PROOF OF INCOME WORKSHEET

Date: ____________________

Patient Status: New Patient Established Patient MRN # ___________________

Name: ____

Date of Birth: ____________________ Social Security Number: _______________________

Phone: __________________________ Marital Status: Single Divorced Married Widowed

Have you applied for Medicare, Medicaid, Primary Care Network (PCN), or Childrens Health Insurance Program (CHIP)?

Yes No

Who provides financial support for you?

Name: ____ Relationship: __________________________

Address: ____ Phone Number: ________________________

Patient Signature: ____ Date: _________________________

The following should be filled out by the person providing financial support

How long has the patient been living with you? Years Months

How much financial support did you provide last month? (i.e. rent, utilities, food, etc.) $______________________

Provide a brief description of the situation:

Patient Supporter Signature: ____ Date: ______________________

SLIDING FEE DISCOUNT PROGRAM

Bethel Family Clinic (BFC) offers discounted services to patients who participate in the **Sliding Fee Discount Program (SFDP)**. To be eligible, you must live on a household income at or below 200% of Federal Poverty Guidelines (FPG). To determine if you live at or below the threshold, your family size and annual income are aligned with poverty guidelines published by the US Department of Health & Human Services. After your proof of income is verified, BFC assigns you a discount category letter, ranging from A-D. The discount category you land in, relative to your income and family size, determines how much of a discount you receive on services and what charge you are responsible to pay after your visit.

2026 Discount Fee Schedule-Poverty Guidelines for Alaska

Slide Level	Slide A	Slide B	Slide C	Slide D	Full Pay
Percentage of FPL:	≤ 100%	101-150%	151-175%	176-200%	Over 200%
Family Size	Annual Income				
1	≤ $19,950	$19,951-$29,925	$29,926-$34,912.50	$34,913-$39,900	≥ $39,901
2	≤ $27,050	$27,051-$40,575	$40,576-$47,337.50	$47,338-$54,100	≥ $54,101
3	≤ $34,150	$34,151-$51,225	$51,226-$59,762.50	$59,763-$68,300	≥ $68,301
4	≤ $41,250	$41,251-$61,875	$61,876-$72,187.50	$72,188-$82,500	≥ $82,501
5	≤ $48,350	$48,351-$72,525	$72,526-$84,612.50	$84,613-$96,700	≥ $96,701
6	≤ $55,450	$55,451-$83,175	$83,176-$97,037.50	$97,038-$110,900	≥ $110,901
7	≤ $62,550	$62,551-$93,825	$93,826-$109,462.50	$109,463-$125,100	≥ $125,101
8	≤ $69,650	$69,651-$104,475	$104,476-$121,887.50	$121,888-$139,300	≥ $139,301
For Families/Households with more than 8 persons, reach out to Business/Operations Director					
Source: U.S. Department of Health and Human Services: Published January 14th 2026					

Example: If you belong to Discount Category A, you are responsible only to pay the nominal charge ($20 for medical services, $40 for dental services, or $0 for behavioral health services). This will be your *only* financial obligation and the remainder of your bill will be discounted. If you below to Discount Category C, you are required to pay a flat charge ($80 for medical services, $120 for dental services, or $10 for behavioral health services). Again, this will be your *only* financial obligation and the remainder of your bill will be discounted.

Supplies: Supplies that are related to, but not included in the service itself are discounted separate from the sliding fee discount program. These items include braces, crutches, partials, crowns, dentures, and other medical and dental equipment.

Discount for supplies will be based on a percentage of charge. Patients will be notified of supply costs at the time the supplies are dispensed.

Supplies 2026 Discount Fee Schedule

Charges for Supplies are Discounted at the Following Rates: Based on Patients Income	
≤ 100% of Federal Poverty Guideline	85% Discount
101-150% of Federal Poverty Guideline	75% Discount
151-175% of Federal Poverty Guideline	50% Discount
176-200% of Federal Poverty Guideline	25% Discount
> 200% of Federal Poverty Guideline	No Discount

Sliding Fee Discount Table-Patient Responsibility Amounts *(Applies only to services provided at clinic sites)*					
Slide Level	**Slide A**	**Slide B**	**Slide C**	**Slide D**	**Full Pay**
Federal Poverty Level	≤100%	101-150%	151-175%	176-200%	>200%
Medical	$20.00 Per encounter	$40.00 Per encounter	$80.00 Per encounter	$120.00 Per encounter	**No Discount, Charges dependent on type of visit.**
Behavioral Health	$0.00 Per encounter	$5.00 Per encounter	$10.00 Per encounter	$15.00 Per encounter	
Dental	$40.00 Per encounter	$80.00 Per encounter	$120.00 Per encounter	$160.00 Per encounter	

Thank you for your participation

----------------------------------To be completed by BFC Staff only -----------------------------------

Patient has qualified for the Following Discount					
☐ Does Not Qualify	☐ Slide A	☐ Slide B	☐ Slide C	☐ Slide D	☐ No Proof of Income

Financial Assistance Approved Until (Date):______________________

Thank you for choosing Bethel Family Clinic as your healthcare provider. Based on the category indicated on the face of this document, please see below for discount detail. If you have any questions regarding your discount please contact Bethel Family Clinic at (907)543-3773 and request to speak with someone about the Sliding Fee Discount Program.

Employee Signature: ____ Date Received: ______________________

What Do I Owe?				
	FPG	Medical	Dental	Behavioral Health
A	0-100%	$20	$40	$0
B	101-150%	$40	$80	$5
C	151-175%	$80	$120	$10
D	176-200%	$120	$160	$15