WAIKIKI HEALTH

MEDICAL & DENTAL • BEHAVIORAL HEALTH • SOCIAL SERVICES

BASIC FINANCIAL ASSISTANCE UNINSURED AND UNDERINSURED ATTESTATION

Waikiki Health offers a Fee Scale (SFS) discount from billed charges for services provided to uninsured and underinsured patients with household income is less than 200 percent of the Federal Poverty Guidelines as outlined in the Department of Health and Human Services, Federally Qualified Health Center (FQHC) program and are effective January 17, 2024. This discount may not be applicable to care received related to an injury where another individual or entity is responsible for payment.

Payment Expectations: To the best of the patient's ability. Waikiki Health expects a payment or deposit at the time of services rendered. Some days after the appointment, the patient will receive in the mail an itemized statement indicating the discounted balance due with contact information to make payment arrangements. These programs are subject to change or cancellation at any time.

ATTESTATION

I attest as the patient or guarantor for this account on the date of signature, that:

- The patient has no insurance for this service.
- The household annual gross income is less than the amount listed below for my family size.
- The patient has provided proof of income.
- If no proof of income is available at the time of service, the patient understands they have two weeks, or until the next office visit, whichever comes first, to provide proof of income. Otherwise, the patient will be charged the full fee.
- If patient falls on sliding fee B or C, patient must apply for Med-QUEST per agency (FQHC) rules.

Please CIRCLE number of people in your household: 1 2 3 4 5 6 7 8

If more than 8, total number of people in your household: _____

Persons in Household	Poverty Guideline (Hawaii)*	Persons in Household	Poverty Guideline (Hawaii)*
1	$17,310	5	$42,070
2	$23,500	6	$48,260
3	$29,690	7	$54,450
4	$35,880	8	$60,640

**Rates from www.aspe.hhs.gov (published January 2024)*

Patient Signature: _____ Date: _____

Printed Patient Name: _____

If the patient does not sign:

Printed Name of Signer: _____ Relationship to Patient: _____

I have reviewed the Sliding Scale program and DECLINE to sign up for this program. I understand that I can complete this form if I change my mind.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

OFFICIAL USE			
DOS		MRN	

rev. 03/24

WAIKIKI HEALTH

MEDICAL & DENTAL • BEHAVIORAL HEALTH • SOCIAL SERVICES

Self-Declaration of Income for Sliding Fee Eligibility

Name: _____ DOB: _____

Address: _____

I am signing this letter to declare that my financial support comes from (please describe):

Dollar amount of monthly financial support: _____

I am unable to provide independent verification because:

I understand that this is a temporary verification and by completing, signing, and dating this form that the information I am providing is true and correct. I understand and agree to submit proof of income to Waikiki Health in order to receive continued assistance. I understand that providing false information regarding my income and not submitting proof of income may result in denial of sliding fee eligibility.

Print Name: _____ Date: _____

Signature: _____

I have reviewed the Sliding Scale program and DECLINE to sign up for this program. I understand that I can complete this form if I change my mind.

Patient Signature: _____ Date: _____

Printed Patient Name: _____