GUAM MEMORIAL HOSPITAL AUTHORITY
SLIDING FEE DISCOUNT PROGRAM

WHAT IS A SLIDING FEE DISCOUNT PROGRAM ?

A program that grants residents a discount on medical services based on their eligibility.

WHO CAN APPLY?

Residents (U.S. Citizens and Permanent Residents) are invited to apply for the Sliding Fee Discount Program.

WHAT IS COVERED UNDER THE DISCOUNT PROGRAM?

The Sliding Fee Discount Program covers medically necessary services at GMH and SNF (Skilled Nursing Facility). Discounts are only applicable for services rendered by GMHA.

Sliding Fee Discount Program will not cover services rendered by GMHA prior to individual's eligibility. For other Financial Assistance Program (FAP), please see our Customer Service Representative.

IMPORTANT FACTS

- This program is not an insurance program. Discounts are for medical services rendered by GMHA.
- All applications and required documents shall be completed prior to submission. Any changes to income after application has been submitted shall be provided to GMHA.
- Sliding Fee Discount Program will cover services three (3) months prior to the date the application was approved.

REQUIREMENTS

- Sliding Fee Discount Program Application is available at the GMHA Patient Registration and Business Office.
- **COPIES OF THE FOLLOWING DOCUMENTS:**
  - Proof of Citizenship or Lawful Permenant Residency (e.g. Passport, Social Security Card or Permanent Residence Card)
  - Valid I.D (e.g. Guam Driver's License, Passport, and Guam I.D.)
  - Birth Certificates of all household members
  - Proof of Income (e.g. Current Check Stubs or Employment Verification, and Self-employed shall provide Tax Form 1040)
  - If applicant is unemployed a Self-Declaration stating financial support.

SOURCES OF INCOME

Reporting earned or unearned income to GMHA is required when submitting an application for the Sliding Fee Discount Program. The following sources of income shall be reported:

- Salaries, Tips, and Wages
- Self-Employment Income
- Workmen's Compensation
- Welfare benefits
- Social Security Benefits and Income
- Pension
- Veteran's Benefit
- Survivor Benefit
- Money from friends and family
- Other income sources

Contact Us! (671) 648-6719 or (671) 647-2430

GUAM MEMORIAL HOSPITAL AUTHORITY
ATURIDÅT ESPETÅT MIMURIÅT GUÅHÅN
850 Governor Carlos Camacho Road, Tamuning, Guam 96913
Operator: (671) 647-2330 or 2552 | Fax: (671) 649-5508

SLIDING FEE DISCOUNT PROGRAM APPLICATION

A. PERSONAL INFORMATION

APPLICANT NAME: _____ DATE OF BIRTH: _____
CO-APPLICANT NAME: _____DATE OF BIRTH: _____
CURRENT MAILING ADDRESS: _____
CURRENT PHYSICAL ADDRESS: _____
APPLICANT E-MAIL: _____ CO-APPLICANT E-MAIL: _____
HOME PHONE: _____ CELLPHONE: _____ OTHER: _____
MARRITAL STATUS (CHECK MARK WHICH APPLIES TO YOU/CO-APPLICANT)
_ SINGLE _ MARRIED _ WIDOW _ DIVORCE/SEPARATED _ COMMON LAW

B. FAMILY FINANCIAL STATUS

	APPLICANT	SPOUSE
OCCUPATION:	_____	_____
EMPLOYER:	_____	_____
ANNUAL GROSS SALARY:	$_____	$_____

OTHER SOURCES OF INCOME (for Applicant, Spouse, and Dependent family members)

	TOTAL AMOUNT
STATE SUPPLEMENTARY PAYMENT	$_____
RETIREMENT, DISABILITY, WORKERS COMPENSATION, SOCIAL SECURITY, UNEMPLOYMENT, AND COMPENSATION	$_____
ALIMONY, CHILD SUPPORT	$_____
DIVEDENDS, INTEREST, GIFT, INHERITANCE	$_____
TOTAL SMMARY AND OTHER RESOURCES:	$

C. DEPENDENTS

LIST THE NAME(S), DATE OF BIRTH, AND AGES(S) OF YOUR DEPENDENTS*
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: _____

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: _____

For official Use Only
Submission Date: _____
Verification Date: _____
EHR/CHART #: _____

PERSONAL STATEMENT

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF ELIGIBILE FOR THE SLIDING FEE 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 GUAM MEMORIAL HOSPITAL AUTHORITY WITHIN FIVE (5) WORKING DAYS OF ANY CHANGE(S) IN MY INCOME STATUS TO REASSES MY ELIGIBILITY FOR THE SLIDING FEE DISCOUNT PROGRAM. I HAVE BEEN NOTIFIED THAT I MUST COMPLETE AND UPDATE A SLIDING FEE APPLICATION ANNUALLY (ONE YEAR FROM MY APPROVED APPLICATION) SO THAT ELIBIBILITY CAN BE DETERMINED ON THE FAMILY SIZE AND INCOME BASED ON THE FEDERAL POVERTY GUIDELINES.

_____ _____

APPLICANT SIGNATURE **DATE**

SLIDING FEE DOCUMENTS NEEDED UPON SUBMISSION OF APPLICATION

This is a Discount Program. Please provide the following:

1. Proof of Citizenship or lawful Permanent Residency (U.S Passport, Social Security, or Green Card)
2. Valid Photo Identification of Applicant and Spouse if applying as Married or Common-law (e.g., Driver's License, Guam I.D., and any valid Passport).
3. Birth Certificate (all household members listed on Section A and Section C. However, if a birth certificate is unavailable, it may be substituted with Mayor's Verification.
4. Check Stubs- Two (2) current check stubs from all working members of the family or Verification of Employment.
    a. If applicant has no financial income, GMH will require 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).
5. Current Contact Number(s). Please ensure that all home, cell, and other numbers are currently working to assure customer receives a call from GMHA Collection Staff regarding application Status.

NOTE: All documents must be copied and turned in with the complete application for processing. 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 GMHA Patient Registration at (671) 648-6719 or (671) 647-2430.

FOR INTERNAL USE ONLY

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

☐ **APPROVED**

- ☐ 100 %
- ☐ 80%
- ☐ 60%
- ☐ 40%
- ☐ 20%

☐ **DISAPPROVED**

REASON FOR DISAPPROVAL OF APPLICATION

- ☐ INCOMPLETE HH INCOME VERIFICATION FROM FAMILY MEMBER(S) SUPPORTING THE APPLICANT.
- ☐ INCOMPLETE APPLICATION (MISSING DEMOGRAPHICS/ SOCIO-ECONOMIC DATA ON THE APPLICATION.)
- ☐ INCOMPLETE SUPPORTING DOCUMENT (MISSING BIRTH CERTIFICATE, EMPLOYMENT CHECK STUB, RESIDENCY VERIFICATION.)
- ☐ INCOME EXCEEDS 200% OF FEDERAL INCOME POVERTY GUIDELINE

APPLICANT WAS CALLED ON: ____/____/____

Staff Name: _____

Signature: _____

Date: _____

Approving Signatory: _____

Date: _____