SVT Health&Wellness
A branch of Seldovia Village Tribe
Partnering in the Journey!

Discount Programs for Eligible Patients

SVT Health & Wellness is pleased to offer discount programs for qualifying patients. Previously, patients were only required to provide a self-attestation of income and household size. However, as of June 15, 2021, patients are required to provide proof of income in order to be eligible for the following discounts:

- Sliding Fee Discount for medical, dental, behavioral health and lab services.
- 340b "Care Card" program offering discounted or free medications.
- Senior Access Grant for dental services provided to patients aged 65+ with no dental insurance.

To maintain your discount, you must submit an application with proof of household income prior to your first appointment.

Any of the following documentation is accepted as proof of income:

- ✓ Three (3) months of household paycheck stubs.
- ✓ Most recently completed income tax return or W2.
- ✓ Social Security, Public Assistance, Unemployment, disability or pension statements or benefit letters.

What defines a "household"? Household residents are people who live together in the same household, sharing expenses and meals (typically a family). Unrelated people living in a shared house who do not share income are not considered to be part of the patient's household (such a "room-mate").

After completing your application and gathering your proof of income documents, please call 907-226-2228 to make an appointment.

We hope to see you soon.

Gary Bradley, Director
SVT Health & Wellness

SVT Health & Wellness Locations:
Homer, Alaska 99603 • 880 East End Road | 907.226.2228 | fax: 907.226.2230
Anchor Point, Alaska 99556 • 72351 Milo Fritz Avenue | 907.226.2238 | fax: 907.226.2336
Seldovia, Alaska 99663 • 206 Main Street | 907.435.3262 | fax: 907.234.7880
Admin fax: 907.226.2343 | **Medical Records** fax: 907.435.3223

SVT Health & Wellness Discount Program Application

Applicant Information

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone contact #: _____

Date of Birth: _____ Number in Household: _____

Insurance Co. (if any): ☐ Medicare ☐ None *☐ Medicaid *☐ IHS Beneficiary

*Not Eligible for Discount Prescription Program

☐ Other: _____

Household Information - list all members of household that are financially responsible for each other

Last Name:		**First Name:**		**DOB:**		**Relation:**	**SELF/APPLICANT**
Last Name:		First Name:		DOB:		Relation:	
Last Name:		First Name:		DOB:		Relation:	
Last Name:		First Name:		DOB:		Relation:	
Last Name:		First Name:		DOB:		Relation:	
Last Name:		First Name:		DOB:		Relation:	

Type of Income Received By Household Member - List all income (ATTACH PROOF)

	Applicant (amount)	Spouse/Partner (amount)	Other Household Member (amount)	Monthly	Yearly
Salary	$	$	$	☐	☐
Self Employment	$	$	$	☐	☐
Unemployment	$	$	$	☐	☐
Social Security	$	$	$	☐	☐
Disability	$	$	$	☐	☐
Other:	$	$	$	☐	☐

SVTH&W Discount Program Agreement

☐ **I understand that proof of income is required for all income sources listed above.**

☐ **I understand I must renew my application every year to continue recieiving the discount**

☐ **I understand it is my responsibility to inform the clinic of any changes in the above information.**

☐ **I certify the information provided on this form is true and accurate.**

☐ **I authorize the clinic to verify any of this information.**

SVT Health & Wellness - Seldovia, Homer, Anchor Point

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Applicant Signature and Date