LifeMed ALASKA
We're on the Way

To be considered for a Charity Discount, the following criteria must be met:

- You do not have access to health insurance through your employer
  - If you choose not to enroll or maintain eligibility, you may be excluded from receiving financial assistance.
- You are not eligible to receive State of Alaska Medicaid Benefits
  - A Medicaid determination letter must be attached, or proof of income exceeds Medicaid minimums.
  - If you choose not to apply for Medicaid assistance, you may be excluded from receiving financial assistance.
- You are not eligible for Medicare benefits
- You are not eligible for VA benefits
- You are not eligible for COBRA benefits
  - If you choose not to continue your COBRA benefits, you may be excluded from receiving financial assistance.

If you are found to be eligible for financial assistance by meeting the criteria established above, you may be eligible for further reductions based on household income. We take into consideration household size, income, and assets.

You may begin the application process by completing the information on the following page. Send the questionnaire back to our office along with:

- Copies of your most recent tax return and most recent bank statements
- Supporting Documentation (awards or denials for public assistance, discount/charity approvals from other institutions, alimony, court order for child support, etc.)
- Verification of value of investments (401K, IRA, Stocks, Bonds, etc.)
- If you claim no income, attach a letter of explanation. If another person is paying for your food, shelter, etc. attach a letter of explanation from them. Also include proof of no income (current tax return, bank statements showing no deposits, etc.)

Post Office Box 190026, Anchorage, Alaska 99519
Phone: (907) 563-6633, Fax: (907) 563-6636
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Financial Questionnaire

Personal Information

Guarantor Name: _____ Phone: _____

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

Patient Name: _____ Service Date(s): _____

Account Number(s): _____ _____

_____ Balance Due: $ _____

Family Size				
Total Family Size: _____	**Name**	**Relationship**	**DOB**	**Citizen Yes or No**
Patient				
Guarantor (if different from patient)				
Spouse				
Child				
Child				
Child				
Child				
Other Family Member				
Other Household Member				
United States Sponsor				

Income (Monthly)				
	Person 1	**Person 2**	**Person 3/Sponsor**	**Grand Total**
Name:				
Gross wages/salary:	$	$	$	$
Employer:				
Phone#:				
Start Date:				
Termination Date:				

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Unemployment	$	$	$	$
Public Assistance (Cash)	$	$	$	$
Social Security	$	$	$	$
Retirement Benefits	$	$	$	$
VA Benefits	$	$	$	$

Checking/Savings Accounts, Investments, and Insurance	**Balance**		
Does your household have a checking account?	☐ Yes	☐ No	$
Does your household have a savings account?	☐ Yes	☐ No	$
Does your household have any Investments, IRA, CD's, etc.?	☐ Yes	☐ No	$
Are you drawing monthly income from Investments?	☐ Yes	☐ No	**Amount per month:** $ _____
Have you applied for Medicaid in the past 90 days? **If yes, what was the determination? (Provide copy of award letter)**	☐ Yes ☐ Approved ☐ Denied	☐ No	**Date:** _____
Do you have Medical Insurance?	☐ Yes	☐ No	

Insurance:	
Policy#	
Group#	
Phone#	
Address:	

List any other properties you own other than your primary residence.	**Type of Property (house, condo, etc)**	**Tax Assessed Value**	**Outstanding Mortgage**
		$	$
		$	$

I understand that the information provided by me is subject to verification by LifeMed Alaska, LLC. I understand that any false information provided by me will result in a denial of any financial assistance. Financial assistance is available only after all other forms of reimbursement (health insurance, Medicaid, or third party insurance) have been exhausted.

Signature: _____ Date: _____

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