Community Health Center of the North Country

Sliding Fee Discount Application 2018

Responsible Person		Today's Date: / /	**Patient Name**	
First Name:	Middle:	Last:	Patients Date of Birth: / /	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -		
Social Security #(***optional***): - -		Do you have insurance? ☐No ☐Yes	If Yes, What Insurance:	
Marital Status: ☐ Single	☐ In a relationship	☐ Married	☐ Divorced	☐ Separated ☐ Widowed

OTHER PEOPLE in your household:

Name	**Date of Birth**	Patient Relationship
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

NOTE: To comply with federal regulations, in order to give you a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Employment Income

Name	**Amount**	**How Often?**	**Employer:**
You	$	☐ Week ☐ Month ☐ Year	
Spouse	$	☐ Week ☐ Month ☐ Year	
Children	$	☐ Week ☐ Month ☐ Year	
Other	$	☐ Week ☐ Month ☐ Year	
	$	☐ Week ☐ Month ☐ Year	
TOTAL	$	☐ Week ☐ Month ☐ Year	

Other Income

	You	**Spouse**	**Children**	**Other**	**How Often?**
Social Security	$	$	$	$	☐ Week ☐ Month ☐ Year
Public Assistance	$	$	$	$	☐ Week ☐ Month ☐ Year
Retirement Pension	$	$	$	$	☐ Week ☐ Month ☐ Year
Disability	$	$	$	$	☐ Week ☐ Month ☐ Year
Child Support/Alimony	$	$	$	$	☐ Week ☐ Month ☐ Year
Interest Income	$	$	$	$	☐ Week ☐ Month ☐ Year
Other	$	$	$	$	☐ Week ☐ Month ☐ Year

For Office Use Only:

☐ Approved ☐ Denied

Household Size: _____

Income:

_____

Patient Designation:

____ **Group A**
____ **Group B**
____ **Group C**
____ **Group D**
____ **Group E**

Authorized Signature:

_____

Date: _____

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Community Health Center of the North Country if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Community Health Center of the North Country. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Name (Please Print):_____

Signature:_____

Sliding Fee Scale Discounts According to Group Designation On Next Page

Sliding Fee Discount According to Group Designation

Eligible Services	Group A	Group B	Group C	Group D	Group E
Primary Care	No Discount	$75	$50	$30	$15
Mental Health	No Discount	$75	$50	$30	$15
Optometry (*Eye Glasses Excluded)	No Discount	$75	$50	$30	$15
*Eye Glasses available at cost. Price Listing available upon request					
Dental Care (*Dentures Excluded)	No Discount	$60	$45	$30	$15
*Patient is responsible for the $350.00 lab fee associated with each denture in addition to the fee per visit listed above					
Chronic Care Management	No Discount	$3	$3	$3	$3

2018 Federal Poverty Guidelines

Household Size	Group A	Group B	Group C	Group D	Group E
Poverty Level	201%	200%	166%	133%	100%
1	24,281	24,280	20,152	16,146	12,140
2	32,921	32,920	27,324	21,892	16,460
3	41,561	41,560	34,495	27,637	20,780
4	50,201	50,200	41,666	33,383	25,100
5	58,841	58,840	48,837	39,129	29,420
6	67,481	67,480	56,008	44,874	33,740
7	76,121	76,120	63,180	50,620	38,060
8	84,761	84,760	70,351	56,365	42,380
9	93,401	93,400	77,522	62,111	46,700
10	102,041	102,040	84,693	67,857	51,020
11	110,681	110,680	91,864	73,602	55,340
12	119,321	119,320	99,036	79,348	59,660
13	127,961	127,960	106,207	85,093	63,980
14	136,601	136,600	113,378	90,839	68,300
15	145,241	145,240	120,549	96,585	72,620