

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 # - -		Do you have insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, What Insurance:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> In a relationship <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> 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	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
Spouse	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
Children	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
Other	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
TOTAL	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	

Other Income					
	You	Spouse	Children	Other	How Often?
Social Security	\$	\$	\$	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
Public Assistance	\$	\$	\$	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
Retirement Pension	\$	\$	\$	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
Disability	\$	\$	\$	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
Child Support/Alimony	\$	\$	\$	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
Interest Income	\$	\$	\$	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
Other	\$	\$	\$	\$	<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> 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 Discount According to Group Designation

<u>Eligible Services</u>	<u>Group A</u>	<u>Group B</u>	<u>Group C</u>	<u>Group D</u>	<u>Group E</u>
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

2019 Federal Poverty Guidelines

	<u>Group A</u>	<u>Group B</u>	<u>Group C</u>	<u>Group D</u>	<u>Group E</u>
Poverty Level	201%	200%	166%	133%	100%
1	24,981	24,980	20,733	16,612	12,490
2	33,821	33,820	28,071	22,490	16,910
3	42,661	42,660	35,408	28,369	21,330
4	51,501	51,500	42,745	34,248	25,750
5	60,341	60,340	50,082	40,126	30,170
6	69,181	69,180	57,419	46,005	34,590
7	78,021	78,020	64,757	51,883	39,010
8	86,861	86,860	72,094	57,762	43,430
9	95,701	95,700	79,431	63,641	47,850
10	104,541	104,540	86,768	69,519	52,270
11	113,381	113,380	94,105	75,398	56,690
12	122,221	122,220	101,443	81,276	61,110
13	131,061	131,060	108,780	87,155	65,530
14	139,901	139,900	116,117	93,034	69,950
15	148,741	148,740	123,454	98,912	74,370

Household Size