Community Health Center of the North Country

Sliding Fee Discount Application 2020

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					
COVID-19 Specimen Collection	No Discount	$20	$15	$10	$5
COVID-19 Point of Care Testing	No Discount	$30	$25	$20	$15

2020 Federal Poverty Guidelines

Household Size	Group A	Group B	Group C	Group D	Group E
Poverty Level	201%	200%	166%	133%	100%
1	25,521	25,520	21,182	16,971	12,760
2	34,481	34,480	28,618	22,929	17,240
3	43,441	43,440	36,055	28,888	21,720
4	52,401	52,400	43,492	34,846	26,200
5	61,361	61,360	50,929	40,804	30,680
6	70,321	70,320	58,366	46,763	35,160
7	79,281	79,280	65,802	52,721	39,640
8	88,241	88,240	73,239	58,680	44,120
9	97,201	97,200	80,676	64,638	48,600
10	106,161	106,160	88,113	70,596	53,080
11	115,121	115,120	95,550	76,555	57,560
12	124,081	124,080	102,986	82,513	62,040
13	133,041	133,040	110,423	88,472	66,520
14	142,001	142,000	117,860	94,430	71,000
15	150,961	150,960	125,297	100,388	75,480