Community Health Center of the North Country

Sliding Fee Discount Application 2021

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? ☐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

2021 Federal Poverty Guidelines

Household Size	Group A	Group B	Group C	Group D	Group E
Poverty Level	201%	200%	166%	133%	100%
1	25,761	25,760	21,381	17,130	12,880
2	34,841	34,840	28,917	23,169	17,420
3	43,921	43,920	36,454	29,207	21,960
4	53,001	53,000	43,990	35,245	26,500
5	62,081	62,080	51,526	41,283	31,040
6	71,161	71,160	59,063	47,321	35,580
7	80,241	80,240	66,599	53,360	40,120
8	89,321	89,320	74,136	59,398	44,660
9	98,401	98,400	81,672	65,436	49,200
10	107,481	107,480	89,208	71,474	53,740
11	116,561	116,560	96,745	77,512	58,280
12	125,641	125,640	104,281	83,551	62,820
13	134,721	134,720	111,818	89,589	67,360
14	143,801	143,800	119,354	95,627	71,900
15	152,881	152,880	126,890	101,665	76,440