Community Health Center of the North Country

Sliding Fee Discount Application 2022

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

2022 Federal Poverty Guidelines

Household Size	Group A	Group B	Group C	Group D	Group E
Poverty Level	201%	200%	166%	133%	100%
1	27,181	27,180	22,559	18,075	13,590
2	36,621	36,620	30,395	24,352	18,310
3	46,061	46,060	38,230	30,630	23,030
4	55,501	55,500	46,065	36,908	27,750
5	64,941	64,940	53,900	43,185	32,470
6	74,381	74,380	61,735	49,463	37,190
7	83,821	83,820	69,571	55,740	41,910
8	93,261	93,260	77,406	62,018	46,630
9	102,701	102,700	85,241	68,296	51,350
10	112,141	112,140	93,076	74,573	56,070
11	121,581	121,580	100,911	80,851	60,790
12	131,021	131,020	108,747	87,128	65,510
13	140,461	140,460	116,582	93,406	70,230
14	149,901	149,900	124,417	99,684	74,950
15	159,341	159,340	132,252	105,961	79,670