Community Health Center of the North Country

Sliding Fee Discount Application 2023

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	No Discount	$75	$50	$30	$15
Dental Care	No Discount	$60	$45	$30	$15
COVID-19 Specimen Collection	No Discount	$20	$15	$10	$5
COVID-19 Point of Care Testing	No Discount	$30	$25	$20	$15

**** Supplies, equipment and lab charges above and beyond the sliding fee charges are the patient's responsibility. Supplies, equipment and lab charges are calculated based on cost plus administrative fees.***

2023 Federal Poverty Guidelines

Household Size	Group A	Group B	Group C	Group D	Group E
Poverty Level	201%	200%	166%	133%	100%
1	29,161	29,160	24,203	19,391	14,580
2	39,441	39,440	32,735	26,228	19,720
3	49,721	49,720	41,268	33,064	24,860
4	60,001	60,000	49,800	39,900	30,000
5	70,281	70,280	58,332	46,736	35,140
6	80,561	80,560	66,865	53,572	40,280
7	90,841	90,840	75,397	60,409	45,420
8	101,121	101,120	83,930	67,245	50,560
9	111,401	111,400	92,462	74,081	55,700
10	121,681	121,680	100,994	80,917	60,840
11	131,961	131,960	109,527	87,753	65,980
12	142,241	142,240	118,059	94,590	71,120
13	152,521	152,520	126,592	101,426	76,260
14	162,801	162,800	135,124	108,262	81,400
15	173,081	173,080	143,656	115,098	86,540