Community Health Center of the North Country

Sliding Fee Discount Application 2024

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.***

2024 Federal Poverty Guidelines

Household Size	Group A	Group B	Group C	Group D	Group E
Poverty Level	201%	200%	166%	133%	100%
1	30,121	30,120	25,000	20,030	15,060
2	40,881	40,880	33,930	27,185	20,440
3	51,641	51,640	42,861	34,341	25,820
4	62,401	62,400	51,792	41,496	31,200
5	73,161	73,160	60,723	48,651	36,580
6	83,921	83,920	69,654	55,807	41,960
7	94,681	94,680	78,584	62,962	47,340
8	105,441	105,440	87,515	70,118	52,720
9	116,201	116,200	96,446	77,273	58,100
10	126,961	126,960	105,377	84,428	63,480
11	137,721	137,720	114,308	91,584	68,860
12	148,481	148,480	123,238	98,739	74,240
13	159,241	159,240	132,169	105,895	79,620
14	170,001	170,000	141,100	113,050	85,000
15	180,761	180,760	150,031	120,205	90,380