Community Health Center of the North Country

# Sliding Fee Discount Application 2025

| **Patient Name** *(Fill out this section)* | | **Responsible Person** *(Income & Employment Info Required)* | | **Today's Date** / / |
|---|---|---|---|---|
| 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 *(Responsible Person)*

| 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 *(Responsible Person)*

| | 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 | $80 | $55 | $35 | $20 |
| Mental Health | No Discount | $80 | $55 | $35 | $20 |
| Optometry | No Discount | $80 | $55 | $35 | $20 |
| Dental Care (Preventative Services/Emergencies) | No Discount | $80 | $55 | $35 | $20 |
| Dental Care (Expanded Dental Procedures)<br>Sealants, Fillings, Periodontics, Extractions, Endodontics, Crowns, Bridges, Partials, Dentures, Prosthetic Repairs, Space Maintainers, Occlusal Guards and Hard/Soft Tissue Modifications | No Discount | 10% Discount^ | 30% Discount^ | 60% Discount^ | $40* |

***If applicable, additional out-of-pocket costs for lab fees will apply.***
***^Discount applied to total service fees.***
***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.***

## 2025 Federal Poverty Guidelines

| Household Size | Group A | Group B | Group C | Group D | Group E |
|---|---|---|---|---|---|
| Poverty Level | 201% | 200% | 166% | 133% | 100% |
| 1 | 31,457 | 31,300 | 25,979 | 20,815 | 15,650 |
| 2 | 42,512 | 42,300 | 35,109 | 28,130 | 21,150 |
| 3 | 53,567 | 53,300 | 44,239 | 35,445 | 26,650 |
| 4 | 64,622 | 64,300 | 53,369 | 42,760 | 32,150 |
| 5 | 75,677 | 75,300 | 62,499 | 50,075 | 37,650 |
| 6 | 86,732 | 86,300 | 71,629 | 57,390 | 43,150 |
| 7 | 97,787 | 97,300 | 80,759 | 64,705 | 48,650 |
| 8 | 108,842 | 108,300 | 89,889 | 72,020 | 54,150 |
| 9 | 119,897 | 119,300 | 99,019 | 79,335 | 59,650 |
| 10 | 130,952 | 130,300 | 108,149 | 86,650 | 65,150 |
| 11 | 142,007 | 141,300 | 117,279 | 93,965 | 70,650 |
| 12 | 153,062 | 152,300 | 126,409 | 101,280 | 76,150 |
| 13 | 164,117 | 163,300 | 135,539 | 108,595 | 81,650 |
| 14 | 175,172 | 174,300 | 144,669 | 115,910 | 87,150 |