North Country Family Health Center

2024 Sliding Fee Discount Program Application

I am applying for a **Discounted Fee** for ☐ **Medical Care** ☐ **Dental Care** ☐ **Both**

Individual Applying for Discounted Fee (Indicate household members to be included in this application below)			**Date: / /**
First Name:	Middle:	Last:	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, name of insurance company:		
Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			

OTHER PEOPLE in your household:

Name	Date of Birth	Social Security Number	Applying for Discounted Fee?
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No

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	
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
Other	$	$	$	$	☐ Week ☐ Month ☐ Year

For Office Use Only:

☐ Approved ☐ Denied

Household Size: _____

Total Gross Income:

_____

MEDICAL	DENTAL
☐ A	☐ A
☐ B	☐ B
☐ C	☐ C
☐ D	☐ D
☐ E	☐ E

Approval 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 North Country Family Health Center 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 North Country Family Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____ Name (Please Print): _____

Signature: _____

Your application is considered PENDING until you receive written approval from North Country Family Health Center, Inc.

01/2024 JLA

North Country Family Health Center

2024 Sliding Fee Discount Program Information

We will ask you to update your Sliding Fee Discount Program Application every 12 months.

As a Federally Qualified Health Center it is our mission is to make sure patients can afford the healthcare they need. That is why we offer qualified patients a **Sliding Fee Discount.**

- Our sliding fee discount is for anyone whose household income is at or below **200% of the Federal Poverty Guidelines.** "Household" includes all people living in the same house or apartment that the primary applicant is financially responsible for.
- After you fill out the Sliding Fee Scale Application, we can tell you how much we can discount your fee. We can use this discount for any amount due and for any services we offer.
- It can take up to two weeks to process completed applications. Your application is considered **PENDING** until you receive written notice that it has been approved.
- ***We will give you the care you need no matter what you can pay***.

How to apply for our sliding fee discount:

Our front desk staff can help you apply. Asking about your household size and income is always done as part of check-in.

To apply for a discount, you must fill out a short form and show us proof of income. If you don't have proof of income on your first visit, we can give you 30 days to bring in one of the documents listed below. Your application can't be approved until we have all the paperwork we need.

What you need to bring for "proof of income":

The following will be accepted as proof of income (**more than one document may be required**):

- A copy of your 2023 tax return
- A copy of your 2023 W-2 (If you did not file a return)
- Pay stubs from last 30 days (4 consecutive weekly or 2 consecutive biweekly)
- Written statement from your employer on their letterhead
- 2024 Social Security Benefits Statement
- Proof of Unemployment income (Determination Letter)
- Proof of Disability income
- Proof of other income (if you have it) like child support, alimony, or pension

****Please note we are unable to accept bank statements as proof of income****

2024 Sliding Fee Schedule
(Based Upon 2024 HHS Federal Poverty Guidelines Effective 01.17.2024)

	ANNUAL GROSS INCOME											
Percentage of Federal Poverty Guidelines	0% -	100%	101% -	125%	126% -	150%	151% -	175%	176% -	200%	Over 200%	Over 200%
Family Size	From	To	From	To	From	To	From	To	From	To	From	To
1	$0	$15,060	$15,061	$18,825	$18,826	$22,590	$22,591	$26,355	$26,356	$30,120	$30,121	and over
2	$0	$20,440	$20,441	$25,550	$25,551	$30,660	$30,661	$35,770	$35,771	$40,880	$40,881	and over
3	$0	$25,820	$25,821	$32,275	$32,276	$38,730	$38,731	$45,185	$45,186	$51,640	$51,641	and over
4	$0	$31,200	$31,201	$39,000	$39,001	$46,800	$46,801	$54,600	$54,601	$62,400	$62,401	and over
5	$0	$36,580	$36,581	$45,725	$45,726	$54,870	$54,871	$64,015	$64,016	$73,160	$73,161	and over
6	$0	$41,960	$41,961	$52,450	$52,451	$62,940	$62,941	$73,430	$73,431	$83,920	$83,921	and over
7	$0	$47,340	$47,341	$59,175	$59,176	$71,010	$71,011	$82,845	$82,846	$94,680	$94,681	and over
8	$0	$52,720	$52,721	$65,900	$65,901	$79,080	$79,081	$92,260	$92,261	$105,440	$105,441	and over
9	$0	$58,100	$58,101	$72,625	$72,626	$87,150	$87,151	$101,675	$101,676	$116,200	$116,201	and over
10	$0	$63,480	$63,481	$79,350	$79,351	$95,220	$95,221	$111,090	$111,091	$126,960	$126,961	and over
Each Additional $5,380												

MEDICAL/BEHAVIORAL HEALTH		A	B	C	D	E	F
All services	per visit	$15	$30	$45	$60	$75	Pays 100% of Charges
DENTAL		**A**	**B**	**C**	**D**	**E**	**F**
Preventative Services/Emergencies	per visit	$15	$30	$45	$60	$75	Pays 100% of Charges
Other Services without Lab Fees	per visit	$40	Pays 40% of Charges	Pays 50% of Charges	Pays 70% of Charges	Pays 90% of Charges	Pays 100% of Charges
Expanded Services with Lab Fees	per visit	$40*	Pays 40% of Charges	Pays 50% of Charges	Pays 70% of Charges	Pays 90% of Charges	Pays 100% of Charges
PHARMACY		**A**	**B**	**C**	**D**	**E**	**F**
340B Acquisition Cost + Dispensing Fee	per script	340B Acquisition Cost + Dispensing Fee $0	340B Acquisition Cost + Dispensing Fee $1.00	340B Acquisition Cost + Dispensing Fee $2.00	340B Acquisition Cost + Dispensing Fee $3.00	340B Acquisition Cost + Dispensing Fee $4.00	Pays 100% of Charges

* Additional out-of-pocket costs for lab fees will apply.