

COOS COUNTY FAMILY HEALTH SERVICES

North Country's Community Health Center

Coos County Family Health Services Sliding Fee Program

At Coos County Family Health Services, we offer a Sliding Fee Program to all of our clients. The Sliding Fee Program assists patients in receiving discounts on services offered at our facility. Once the application process has been completed, the Sliding Fee will be applicable on the following,

- Office visits and procedures
- Co-insurance balances after insurance has processed claim
- Deductible balances after insurance has processed claim
- Supplies

**However, the Sliding Fee Discount does not apply to Orthotics, Co-pay balances, DOT physicals, Employment physicals, or School physicals.*

To see if you qualify for the program you must;

1. Gather all your household financial income (See attached form for financial documentation requirements)
2. Complete and Return Application by one of the methods listed below

-Mail to
Coos County Family Health Services
Attn: Elana Pouliot
133 Pleasant Street
Berlin, NH 03570

-Drop off application at any of our locations
2 Broadway St 133 Pleasant St 59 Page Hill
Gorham, NH 03581 Berlin, NH 03570 Berlin, NH 03570

-Schedule an appointment with our billing department. Last names beginning with A - K please contact Julia A. at (603)752-2040 and Last names that begin with L-Z please contact Elana P. at (603)752-2040.

Financial Documentation Requirements include the following:

1. Four current pay stubs or a complete copy of current Tax return
2. Child Support
3. Public Assistance
4. Social Security
5. Disability
6. Workers Compensation
7. Retirement/Pension
8. Alimony
9. Unemployment

**Coos County Family Health Services
Income Guidelines as of January 2010**

Family Size		A - \$10 Fee		B-80% Discount/\$10 Min		C-60% Discount		D-40% Discount		E-0% Discount	
		From	To	From	To	From	To	From	To	From	To
1	Yearly	0	10,830	10,831	14,404	14,405	18,194	18,195	21,660	21,661	+
	Monthly	0	903	904	1,200	1,201	1,516	1,517	1,805	1,806	+
	Weekly	0	208	209	277	278	350	351	417	418	+
2	Yearly	0	14,570	14,571	19,378	19,379	24,478	24,479	29,140	29,141	+
	Monthly	0	1,214	1,215	1,615	1,616	2,040	2,041	2,428	2,429	+
	Weekly	0	280	281	373	374	471	472	560	561	+
3	Yearly	0	18,310	18,311	24,352	24,353	30,761	30,762	36,620	36,621	+
	Monthly	0	1,526	1,527	2,029	2,030	2,563	2,564	3,052	3,053	+
	Weekly	0	352	353	468	469	592	593	704	705	+
4	Yearly	0	22,050	22,051	29,327	29,328	37,044	37,045	44,100	44,101	+
	Monthly	0	1,838	1,839	2,444	2,445	3,087	3,088	3,675	3,676	+
	Weekly	0	424	425	564	564	712	713	848	849	+
5	Yearly	0	25,790	25,791	34,301	34,302	43,327	43,328	51,580	51,581	+
	Monthly	0	2,149	2,150	2,858	2,859	3,611	3,612	4,298	4,299	+
	Weekly	0	496	497	660	661	833	834	992	993	+
6	Yearly	0	29,530	29,531	39,275	39,276	49,610	49,611	59,060	59,061	+
	Monthly	0	2,461	2,462	3,273	3,274	4,134	4,135	4,922	4,923	+
	Weekly	0	568	569	755	756	954	955	1,136	1,137	+
Add the following amounts for each additional family member over 6	Yearly		3,740		4,974		6,283		7,480		7,480
	Monthly		312		415		524		623		623
	Weekly		72		96		121		144		144

Sliding Fee Discount Application

Patient Name _____

Street Address _____

City, State, Zip Code _____

Home Telephone _____

Work Telephone _____

Please list all members of your household (Add one more if you are pregnant by placing a check mark on this line ___)

Household Members	Name	Relationship to You	DOB	Male/Female	Gross Weekly Income

Patient Signature (or responsible party) _____ Date _____

Office Use Only	Total Household Members: _____ Total Household Income: \$ _____ Monthly _____ Annual _____
	Discount: SP A B C D E Discount Card Effective: _____ Expiration Date: _____
	Employee signature: _____ Date: _____

*All Applications must be returned within 30 days from
Date _____ Initial _____