

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 2011

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	
1	Yearly	0	10,890	10,891	14,484	14,485	18,295	18,296	21,780	21,781	+
	Monthly	0	908	909	1,207	1,208	1,525	1,526	1,815	1,816	+
	Weekly	0	209	210	279	280	352	353	419	420	+
2	Yearly	0	14,710	14,711	19,564	19,565	24,713	24,714	29,420	29,421	+
	Monthly	0	1,226	1,227	1,630	1,631	2,059	2,060	2,452	2,453	+
	Weekly	0	283	284	376	377	475	476	566	567	+
3	Yearly	0	18,530	18,531	24,645	24,646	31,130	31,131	37,060	37,061	+
	Monthly	0	1,544	1,545	2,054	2,055	2,594	2,595	3,088	3,089	+
	Weekly	0	356	357	474	475	599	600	713	714	+
4	Yearly	0	22,350	22,351	29,726	29,727	37,548	37,549	44,700	44,701	+
	Monthly	0	1,863	1,864	2,477	2,478	3,129	3,130	3,725	3,726	+
	Weekly	0	430	431	572	573	722	723	860	861	+
5	Yearly	0	26,170	26,171	34,806	34,807	43,966	43,967	52,340	52,341	+
	Monthly	0	2,181	2,182	2,901	2,902	3,664	3,665	4,362	4,363	+
	Weekly	0	503	504	669	670	845	846	1,007	1,008	+
6	Yearly	0	29,990	29,991	39,887	39,888	50,383	50,384	59,980	59,981	+
	Monthly	0	2,499	2,500	3,324	3,325	4,199	4,200	4,998	4,999	+
	Weekly	0	577	578	767	768	969	970	1,153	1,154	+
Add the following amounts for each additional family member over 6	Yearly		3,820		5,081		6,418		7,640		7,640
	Monthly		318		423		535		637		637
	Weekly		73		98		123		147		147

Sliding Fee Discount Application

Patient Name _____ Date of Birth: ___/___/_____

Street Address _____

City, State, Zip Code _____

Home Telephone _____

Work Telephone _____

How many people are currently living in your household? Please circle one.

1 2 3 4 5 6 7 8 9 10 11 12

Are you currently pregnant? Please circle one. **Y / N**

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

Patient Signature (or responsible party) _____ Date _____

Office Use Only	Total Household Members: _____ Total Household Income: \$ _____ \$ _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Monthly Annual </div>
	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 _____