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/Deductible balances after insurance has processed claim
- Deductible balances after insurance has processed claim
- Level E (20% discount) will only be applicable to Family Planning Services.

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

   -If you have any questions please contact Elana Pouliot at (603)342-0215

Financial Documentation Requirements include the following;

1. Four current pay stubs or a complete copy of current Tax return
2. Social Security/Disability Income
3. Workers Compensation
4. Retirement/Pension
5. Unemployment
6. Notice of Decision from Department of Health and Human Services
7. Self-Employment Income Logs/1099

Coos County Family Health Services
Income Guidelines as of March 1, 2020

FAMILY SIZE	INCOME	A - 0-100% Medical $10 Fee Dental $25 Fee		B - 80% DISCOUNT 101-133% Medical $20 Fee Dental $30 Fee		C - 60% DISCOUNT 134-168%		D - 40% DISCOUNT 169-200%		E - 20% DISCOUNT* 201-250%	
1	Annual	$0	$12,760	$12,761	$16,971	$16,972	$21,437	$21,438	$25,520	$25,521	$31,900
	Monthly	$0	$1,063	$1,064	$1,414	$1,415	$1,786	$1,787	$2,127	$2,128	$2,658
	Weekly	$0	$245	$246	$326	$327	$412	$413	$491	$492	$613
2	Annual	$0	$17,240	$17,241	$22,929	$22,930	$28,963	$28,964	$34,480	$34,481	$43,100
	Monthly	$0	$1,437	$1,438	$1,911	$1,912	$2,414	$2,415	$2,873	$2,874	$3,592
	Weekly	$0	$332	$333	$441	$442	$557	$558	$663	$664	$829
3	Annual	$0	$21,720	$21,721	$28,888	$28,889	$36,490	$36,491	$43,440	$43,441	$54,300
	Monthly	$0	$1,810	$1,811	$2,407	$2,408	$3,041	$3,042	$3,620	$3,621	$4,525
	Weekly	$0	$418	$419	$556	$557	$702	$703	$835	$836	$1,044
4	Annual	$0	$26,200	$26,201	$34,846	$34,847	$44,016	$44,017	$52,400	$52,401	$65,500
	Monthly	$0	$2,183	$2,184	$2,904	$2,905	$3,668	$3,669	$4,367	$4,368	$5,458
	Weekly	$0	$504	$505	$670	$671	$846	$847	$1,008	$1,009	$1,260
5	Annual	$0	$30,680	$30,681	$40,804	$40,805	$51,542	$51,543	$61,360	$61,361	$76,700
	Monthly	$0	$2,557	$2,558	$3,400	$3,401	$4,295	$4,296	$5,113	$5,114	$6,392
	Weekly	$0	$590	$591	$785	$786	$991	$992	$1,180	$1,181	$1,475
6	Annual	$0	$35,160	$35,161	$46,763	$46,764	$59,069	$59,070	$70,320	$70,321	$87,900
	Monthly	$0	$2,930	$2,931	$3,897	$3,898	$4,922	$4,923	$5,860	$5,861	$7,325
	Weekly	$0	$676	$677	$899	$900	$1,136	$1,137	$1,352	$1,353	$1,690
*Add the following Amounts for Each Additional Family Member (over 6):	Annual		$4,480		$5,958		$7,526		$8,960		$11,200
	Monthly		$373		$497		$627		$747		$933
	Weekly		$86		$115		$145		$172		$215

***Level E (20% Discount) applies to Family Planning Services only.**

Please allow 30 days for your application to be processed prior to contacting our office

Sliding Fee Discount Application

Patient Name________________________ Date of Birth:___/___/______

Street Address______________________

City, State, Zip Code__________________

Home Telephone______________________ Work Telephone__________________

Are you applying for: Medical______ Dental______ Both_________

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_________

*By signing above you are stating that the information you have provided is true, and you are authorizing CCFHS to verify that information.

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 Distributed: ___________ Staff Initials: ________
Date Received: ______________ Staff Initials: ________

Dental Care
Date/Staff Initials: ___________
Expedite: Yes or No

(Revised 03/2020)