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
- Level E (20% discount) will only be applicable to Family Planning Services.

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.**

coös county
Family Health

Financial Documentation Requirements include the following;

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

Coos County Family Health Services
Income Guidelines as of March 1, 2018

Family Size		A - $10 Fee 0-100%		B-80% Discount/$10 Min 101-133%		C-60% Discount 134-168%		D-40% Discount 169-200%		E-20% Discount * 201-250%	
1	Yearly	0	12,140	12,141	16,146	16,147	20,395	20,396	24,280	24,281	30,350
	Monthly	0	1,012	1,013	1,346	1,347	1,700	1,701	2,023	2,024	2,529
	Weekly	0	233	234	311	312	392	393	467	468	584
2	Yearly	0	16,460	16,461	21,892	21,893	27,653	27,654	32,920	32,291	41,150
	Monthly	0	1,372	1,373	1,824	1,825	2,304	2,305	2,743	2,744	3,429
	Weekly	0	317	318	421	422	532	533	633	634	791
3	Yearly	0	20,780	20,781	27,637	27,638	34,910	34,911	41,560	41,561	51,950
	Monthly	0	1,732	1,733	2,303	2,304	2,909	2,909	3,463	3,464	4,329
	Weekly	0	400	401	531	532	671	671	799	800	999
4	Yearly	0	25,100	25,101	33,383	33,384	42,168	42,169	50,200	50,201	62,750
	Monthly	0	2,092	2,093	2,782	2,783	3,514	3,515	4,183	4,184	5,229
	Weekly	0	483	484	642	643	811	812	965	966	1,207
5	Yearly	0	29,420	28,421	39,129	39,130	49,426	49,427	58,840	58,841	73,550
	Monthly	0	2,452	2,453	3,261	3,262	4,119	4,120	4,903	4,904	6,129
	Weekly	0	566	567	752	753	950	951	1,132	1,133	1,414
6	Yearly	0	33,740	33,741	44,874	44,875	56,683	56,684	67,480	67,481	84,350
	Monthly	0	2,812	2,813	3,740	3,741	4,724	4,725	5,623	5,624	7,029
	Weekly	0	649	650	863	864	1,090	1,091	1,298	1,299	1,622
Add the following amounts for each additional family member over 6	Yearly		4,320		5,746		7,258		8,640		10,800
	Monthly		360		479		605		720		900
	Weekly		83		110		140		166		208

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

coös county Family Health

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 2/2018)