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.**

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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, 2017

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	12,060	12,061	16,040	16,041	20,261	20,262	24,120	24,121	30,150
	Monthly	0	1,005	1,006	1,337	1,338	1,688	1,689	2,010	2,011	2,513
	Weekly	0	232	233	308	309	390	391	464	465	580
2	Yearly	0	16,240	16,241	21,599	21,600	27,283	27,284	32,480	32,481	40,050
	Monthly	0	1,353	1,354	1,800	1,801	2,274	2,275	2,707	2,708	3,338
	Weekly	0	312	313	415	416	525	526	625	626	770
3	Yearly	0	20,420	20,421	27,159	27,160	34,306	34,307	40,840	40,841	50,400
	Monthly	0	1,702	1,703	2,263	2,264	2,859	2,860	3,403	3,404	4,200
	Weekly	0	393	394	522	523	660	661	785	786	969
4	Yearly	0	24,600	24,601	32,718	32,719	41,328	41,329	49,200	49,201	60,750
	Monthly	0	2,050	2,051	2,727	2,728	3,444	3,445	4,100	4,101	5,063
	Weekly	0	473	474	629	630	795	796	946	947	1,168
5	Yearly	0	28,780	28,781	38,277	38,278	48,350	48,351	57,560	57,561	71,100
	Monthly	0	2,398	2,399	3,190	3,191	4,029	4,030	4,797	4,798	5,925
	Weekly	0	553	554	736	737	930	931	1,107	1,108	1,367
6	Yearly	0	32,960	32,961	43,837	43,838	55,373	55,374	65,920	65,921	81,450
	Monthly	0	2,747	2,748	3,653	3,654	4,614	4,615	5,493	5,494	6,788
	Weekly	0	634	635	843	844	1,065	1,066	1,268	1,269	1,566
Add the following amounts for each additional family member over 6	Yearly		4,180		5,559		7,022		8,360		10,450
	Monthly		348		463		585		697		871
	Weekly		80		107		135		161		201

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

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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 2/2017)