**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
- 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.
   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, 2019

| FAMILY SIZE | INCOME | 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 | Annual | $0 | $12,490 | $12,491 | $16,612 | $16,613 | $20,983 | $21,984 | $24,980 | $24,981 |
| | Monthly | $0 | $1,041 | $1,042 | $1,384 | $1,385 | $1,749 | $1,750 | $2,082 | $2,083 |
| | Weekly | $0 | $240 | $241 | $319 | $320 | $404 | $405 | $480 | $481 |
| 2 | Annual | $0 | $16,910 | $16,911 | $22,490 | $22,491 | $28,409 | $28,410 | $33,820 | $33,821 |
| | Monthly | $0 | $1,409 | $1,410 | $1,874 | $1,874 | $2,367 | $2,368 | $2,818 | $2,819 |
| | Weekly | $0 | $325 | $326 | $433 | $434 | $546 | $547 | $650 | $651 |
| 3 | Annual | $0 | $21,330 | $21,331 | $28,369 | $28,370 | $35,834 | $35,835 | $42,660 | $42,661 |
| | Monthly | $0 | $1,778 | $1,779 | $2,364 | $2,365 | $2,986 | $2,987 | $3,555 | $3,556 |
| | Weekly | $0 | $410 | $411 | $546 | $547 | $689 | $690 | $820 | $821 |
| 4 | Annual | $0 | $25,750 | $25,751 | $34,248 | $34,249 | $43,260 | $43,261 | $51,500 | $51,501 |
| | Monthly | $0 | $2,146 | $2,147 | $2,854 | $2,854 | $3,605 | $3,606 | $4,292 | $4,293 |
| | Weekly | $0 | $495 | $496 | $659 | $660 | $832 | $833 | $990 | $991 |
| 5 | Annual | $0 | $30,170 | $30,171 | $40,126 | $40,127 | $50,686 | $50,686 | $60,340 | $60,341 |
| | Monthly | $0 | $2,514 | $2,515 | $3,344 | $3,345 | $4,224 | $4,225 | $5,028 | $5,029 |
| | Weekly | $0 | $580 | $581 | $772 | $773 | $975 | $976 | $1,160 | $1,161 |
| 6 | Annual | $0 | $34,590 | $34,591 | $46,005 | $46,006 | $58,111 | $58,112 | $69,180 | $69,181 |
| | Monthly | $0 | $2,883 | $2,884 | $3,834 | $3,834 | $4,843 | $4,844 | $5,765 | $5,766 |
| | Weekly | $0 | $665 | $666 | $885 | $886 | $1,118 | $1,119 | $1,330 | $1,331 |
| *Add the following Amounts for Each Additional Family Member (over 6): | Annual | | $4,420 | | $5,879 | | $7,426 | | $8,840 | |
| | Monthly | | $368 | | $490 | | $619 | | $737 | |
| | Weekly | | $85 | | $113 | | $143 | | $170 | |

***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 1/2019)