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

-If you have questions and would like to apply in person you can 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)342-0215.**

Financial Documentation Requirements include the following;

1. Four current pay stubs or a complete copy of current Tax return
2. Social Security Compensation
3. Disability Compensation
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, 2016

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	11,880	11,881	15,800	15,801	19,958	19,959	23,760	23,761	+
	Monthly	0	990	991	1,317	1,318	1,663	1,664	1,980	1,981	+
	Weekly	0	228	229	304	305	384	385	457	458	+
2	Yearly	0	16,020	16,021	21,307	21,308	26,914	26,915	32,040	32,041	+
	Monthly	0	1,335	1,336	1,776	1,777	2,243	2,244	2,670	2,671	+
	Weekly	0	308	309	410	411	518	519	616	617	+
3	Yearly	0	20,160	20,161	26,813	26,814	33,869	33,870	40,320	40,321	+
	Monthly	0	1,680	1,681	2,234	2,235	2,822	2,823	3,360	3,361	+
	Weekly	0	388	389	516	517	651	652	775	776	+
4	Yearly	0	24,300	24,301	32,319	32,320	40,824	40,825	48,600	48,601	+
	Monthly	0	2,025	2,026	2,693	2,694	3,402	3,403	4,050	4,051	+
	Weekly	0	467	468	622	623	785	786	935	936	+
5	Yearly	0	28,440	28,441	37,825	37,826	47,779	47,780	56,880	56,881	+
	Monthly	0	2,370	2,371	3,152	3,153	3,982	3,983	4,740	4,741	+
	Weekly	0	547	548	727	728	919	920	1,094	1,095	+
6	Yearly	0	32,580	32,581	43,331	43,332	54,734	54,735	65,160	65,161	+
	Monthly	0	2,715	2,716	3,611	3,612	4,561	4,562	5,430	5,431	+
	Weekly	0	627	628	833	834	1,053	1,054	1,253	1,254	+
Add the following amounts for each additional family member over 6	Yearly		4,160		5,533		6,989		8,320		8,320
	Monthly		347		461		582		693		693
	Weekly		80		106		134		160		160

***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 6/2016)