North Country Family Health Center

Sliding Fee Discount Program Information

As a Federally Qualified Health Center it is our mission is to make sure patients can afford the healthcare they need. That is why we offer qualified patients a **Sliding Fee Discount.**

- Our sliding fee discount is for anyone whose household income is at or below **200% of the Federal Poverty Guidelines.** "Household" includes all people living in the same house or apartment that the primary applicant is financially responsible for.
- After you fill out the Sliding Fee Scale Application we can tell you how much we can discount your fee. We can use this discount for any amount due and for any services we offer.
- It can take up to two weeks to process completed applications. Your application is considered **PENDING** until you receive written notice that it has been approved.
- We will give you the care you need no matter what you can pay.

How to apply for our sliding fee discount:

Our front desk staff can help you apply. Asking about your household size and income is always done as part of check-in.

To apply for a discount you must fill out a short form and show us proof of income. If you don't have proof of income on your first visit, we can give you 30 days to bring in one of the documents listed below. Your application can't be approved until we have all of the paperwork we need.

What you need to bring for "proof of income":

If you are **EMPLOYED**:

Bring in **ONE** of the following items:

- a copy of last year's income tax return
- a W-2 (If you did not file a return)
- pay stubs from last 30 days
- written statement from your employer

If you are **NOT EMPLOYED:**

- Proof of Social Security income
- Proof of Unemployment income
- Proof of Disability income
- Proof of other income (if you have it) like child support, alimony, or pension

We will ask you to update your Sliding Fee Discount Program Application every year.

North Country Family Health Center

Sliding Fee Discount Program Application

I am applying for a **Discounted Fee** for ☐ **Medical Care** ☐ **Dental Care** ☐ **Both**

Individual Applying for Discounted Fee (Indicate household members to be included in this application below)			**Date: / /**
First Name:	Middle:	Last:	Date of Birth: / /
Home Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone #: ( ) -	Cell Phone #: ( ) -		
Social Security # - -	Do you have insurance? ☐No ☐Yes If yes, name of insurance company:		
Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			

OTHER PEOPLE in your household:

Name	Date of Birth	Social Security Number	Applying for Discounted Fee?
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No

To comply with federal regulations, in order to give you a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Employment Income

Name	Amount	How Often?	Employer:
You	$	☐ Week ☐ Month ☐ Year	
Spouse	$	☐ Week ☐ Month ☐ Year	
Children	$	☐ Week ☐ Month ☐ Year	
Other	$	☐ Week ☐ Month ☐ Year	
TOTAL	$	☐ Week ☐ Month ☐ Year	

Other Income

	You	Spouse	Children	Other	How Often?
Social Security	$	$	$	$	☐ Week ☐ Month ☐ Year
Public Assistance	$	$	$	$	☐ Week ☐ Month ☐ Year
Retirement Pension	$	$	$	$	☐ Week ☐ Month ☐ Year
Disability	$	$	$	$	☐ Week ☐ Month ☐ Year
Child Support/Alimony	$	$	$	$	☐ Week ☐ Month ☐ Year
Other	$	$	$	$	☐ Week ☐ Month ☐ Year

For Office Use Only:

☐ Approved ☐ Denied

Household Size: _____

Total Gross Income:

_____

MEDICAL	DENTAL
☐ A	☐ A
☐ B	☐ B
☐ C	☐ C
☐ D	☐ D
☐ E	☐ E

Approval Signature:

_____

Date: _____

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform North Country Family Health Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of North Country Family Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____ Name (Please Print): _____

Signature: _____

Your application is considered PENDING until you receive written approval from North Country Family Health Center, Inc.

7/2018 KMC

2018 Sliding Fee Schedule
(Based Upon 2018 HHS Federal Poverty Guidelines Effective 02.01.2018)

	ANNUAL GROSS INCOME											
Percentage of Federal Poverty Guidelines	0% -	100%	101% -	125%	126% -	150%	151% -	175%	176% -	200%	Over 200%	Over 200%
Family Size	From	To	From	To	From	To	From	To	From	To	From	To
1	$0	$12,140	$12,141	$15,175	$15,176	$18,210	$18,211	$21,245	$21,246	$24,280	$24,281	and over
2	$0	$16,460	$16,461	$20,575	$20,576	$24,690	$24,691	$28,805	$28,806	$32,920	$32,921	and over
3	$0	$20,780	$20,781	$25,975	$25,976	$31,170	$31,171	$36,365	$36,366	$41,560	$41,561	and over
4	$0	$25,100	$25,101	$31,375	$31,376	$37,650	$37,651	$43,925	$43,926	$50,200	$50,201	and over
5	$0	$29,420	$29,421	$36,775	$36,776	$44,130	$44,131	$51,485	$51,486	$58,840	$58,841	and over
6	$0	$33,740	$33,741	$42,175	$42,176	$50,610	$50,611	$59,045	$59,046	$67,480	$67,481	and over
7	$0	$38,060	$38,061	$47,575	$47,576	$57,090	$57,091	$66,605	$66,606	$76,120	$76,121	and over
8	$0	$42,380	$42,381	$52,975	$52,976	$63,570	$63,571	$74,165	$74,166	$84,760	$84,761	and over
9	$0	$46,700	$46,701	$58,375	$58,376	$70,050	$70,051	$81,725	$81,726	$93,400	$93,401	and over
10	$0	$51,020	$51,021	$63,775	$63,776	$76,530	$76,531	$89,285	$89,286	$102,040	$102,041	and over
Each Additional	$0	$4,320	$4,321	$5,400	$5,401	$6,480	$6,481	$7,560	$7,561	$8,640	$8,641	and over

MEDICAL/BEHAVIORAL HEALTH		A	B	C	D	E	F
All services	per visit	$15	$30	$45	$60	$75	Full Fee
DENTAL		**A**	**B**	**C**	**D**	**E**	**F**
Preventative Services/Emergencies	per visit	$15	$30	$45	$60	$75	Full Fee
Sealants	per code	$23	$27	$32	$36	$41	Full Fee
Fillings - Amalgam	per code	$60	$72	$84	$96	$108	Full Fee
Fillings - Resin-Based Composite	per code	$70	$84	$98	$112	$126	Full Fee
Periodontics	per code	$58	$69	$81	$92	$104	Full Fee
Extractions	per code	$50	$60	$70	$80	$90	Full Fee
Endodontics	per code	$310	$372	$434	$496	$558	Full Fee
Crown	per code	$490	$588	$686	$784	$882	Full Fee
Bridge	per code	$453	$543	$634	$724	$815	Full Fee
Partial - Resin - Upper/Lower	per code	$538	$645	$753	$860	$968	Full Fee
Partial - Metal - Upper/Lower	per code	$623	$747	$872	$996	$1,121	Full Fee
Denture - Complete - Upper/Lower	per code	$553	$663	$774	$884	$995	Full Fee
Partial/Denture - Relining	per code	$175	$210	$245	$280	$315	Full Fee
Minor Prosthetic Repair	per code	$60	$72	$84	$96	$108	Full Fee
Major Prosthetic Repair	per code	$86	$103	$120	$137	$154	Full Fee
Space Maintainer	per code	$143	$171	$200	$228	$257	Full Fee
Space Maintainer - Recementation or Removal	per code	$35	$42	$49	$56	$63	Full Fee
Occlusal Guard	per code	$303	$363	$424	$484	$545	Full Fee
Hard/Soft Tissue Modification	per code	$155	$186	$217	$248	$279	Full Fee