Date application received at NCHC____/____/____

Received by: ___________________________

Northern Counties Health Care Application for Sliding Fee Scale FY25

APPLICANT NAME: ____ **SS#** ___________________

ADDRESS: ____

____

DATE OF BIRTH: ________/______/__________ **TELEPHONE:** ____

PLEASE CHECK THE KIND OF INSURANCE YOU HAVE: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-Pay

ARE YOU CURRENTLY ELIGIBLE FOR MEDICAID? ☐ Yes ☐ No ☐ Don't Know

HOUSEHOLD MEMBERS:
(Household members include spouse, partner, dependent children, relatives that depend on the household income.)

NAME		**DATE OF BIRTH**	**PATIENT AT NCHC**	
Self:	____________________________________	______/______/________	☐ YES	☐ NO
Spouse:	____________________________________	______/______/________	☐ YES	☐ NO
Dependent:	____________________________________	______/______/________	☐ YES	☐ NO
Dependent:	____________________________________	______/______/________	☐ YES	☐ NO
Dependent:	____________________________________	______/______/________	☐ YES	☐ NO
Dependent:	____________________________________	______/______/________	☐ YES	☐ NO
Dependent:	____________________________________	______/______/________	☐ YES	☐ NO

TOTAL FAMILY SIZE: ___________

PLEASE NOTE:

- Co-pays and deductibles are eligible for the Sliding Fee Scale
- Patients on the Sliding Fee Scale must re-apply annually in April as Federal Poverty Guidelines change.
- The discount will apply to all services received at our office.
- Patients with an approved sliding fee scale are eligible for reduced or nominal fees on select laboratory and diagnostic imaging at our affiliated referral partners (Copley, Northeastern Vermont Regional, and North Country).
- Services purchased from outside agencies will not be discounted.
- If there are special financial circumstances that you would like considered, please ask to speak with the Practice Manager.

GROSS ANNUAL HOUSEHOLD INCOME					
SOURCE	SELF	HOUSEHOLD MEMBER	HOUSEHOLD MEMBER	HOUSEHOLD MEMBER	Provide the following proof
Income from employment:					Current tax return, Last year’s W2, or 3 consecutive pay stubs or letter from employer.
Unemployment Compensation					DOL Documents
Social security, pension, annuity, veteran's benefits					Current SS award Letter. Current tax return or proof of pension.
Alimony, child support, military family allotments					Court documents for Alimony and child support. Current tax return
Income self-employment					Current tax return including Schedule C. Profit & Loss
Rent, interest, dividend, and other income					Current tax return ? self-attestation may apply
Public Assistance i.e. welfare assistance, (excluding food stamps & fuel assistance)					self-attestation
TOTAL INCOME					

Proof of all sources of income required at time of application including copies of court orders, if applicable.

I hereby certify that the above information is true and accurate to the best of my knowledge. I agree to provide any documentation requested and authorize the health center to verify all information provided. **I understand that payment must be paid at the time of the visit or no fee reduction may be offered for that visit**. The minimum payment for a medical visit is $10.00. The minimum payment for a dental visit is obtained from the Dental Sliding Fee Discount Schedule based on the procedure(s) received. If any information I have given proves to be untrue, I understand that the health center may re-evaluate my financial status and take whatever action becomes appropriate.

____ _________/______/__________

Applicant Signature **Date**

FOR OFFICE USE ONLY:

Approved/Denied by:____DATE:________ ❑ Patient letter sent

Stating Date________/______/________Ending Date: ______/_____/______

PM review and approval: ____DATE:_________________

❑App and supporting documents uploaded to Athena ❑ Self-attestation completed for any income needed.