Northern Counties
HEALTH CARE

Date Received: _____/_____/_____

Initials: _____

Northern Counties Health Care Application for Sliding Fee Scale FY19

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 either the Practice Manager or Chronic Care Coordinator.

GROSS ANNUAL HOUSEHOLD INCOME					
SOURCE	SELF	HOUSEHOLD MEMBER	HOUSEHOLD MEMBER	HOUSEHOLD MEMBER	TOTAL
Gross wages, salaries, tips, etc.					
Unemployment compensation					
Social security, pension, annuity, veteran's benefits					
Alimony, child support, military family allotments					
Income from business, self-employment					
Rent, interest, dividend, and other income					
Public Assistance i.e. welfare assistance, (excluding food stamps & fuel assistance)					
TOTAL INCOME					

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

Employed (*one of the following*)	**Unemployed** (*all that apply*)
• Copy of most recent income tax return	• Public Assistance check stub/copy
• Three most recent pay stubs	• Social Security letter of award
• Written statement from employer stating hours/week, hourly wage, paid weekly or bi-weekly	• Letter of Declaration from 501(c)(3) organization such as a Church
	• Self-attestation form

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:

☐ Denial_____ ☐ Approval _____ Rate Reduction: _____

Approved/Denied by: _____ Date: _____/_____/_____

Stating Date _____/_____/_____ Ending Date: _____/_____/_____