GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

FOR OFFICE USE - PATIENT NOTIFICATION
☐ **APPROVAL** ☐ **DENIAL** Expires:_____
Sliding Fee Category & Discount: _____/_____

Please find your family size then follow that row across and circle the level closest to your **annual household income**. This helps us meet the requirements of the state and federal grants we receive.

Family Size	Between	Between	Between	Between	Over
1	$0 - $12,880	$12,881 - $17,774	$17,775 - $21,896	$21,897 - $25,760	$25,761
2	$0 - $17,420	$17,421 - $24,040	$24,041 - $29,614	$29,615 - $34,840	$34,841
3	$0 - $21.960	$21,961 - $30,305	$30,306 - $37,332	$37,333 - $43,920	$43,921
4	$0 - $26,500	$26,501 - $36,570	$36,571 - $45,050	$45,051 - $53,000	$53,001
5	$0 - $31,040	$31,041 - $42,835	$42,836 - $52,768	$52,769 - $62,080	$62,081
6	$0 - $35,580	$35,581 - $49,100	$49,101 - $60,486	$60,487 - $71,160	$71,161
7+	$0 - $40,120	$40,121 - $55,366	$55,367 - $68,204	$68,205 - $80,240	$80,241

SLIDING FEE DISCOUNT APPLICATION Greater Seacoast Community Health offers a discount based on income for patients who are uninsured, or whose insurance doesn't cover certain services (such as dental or behavioral health care).

To apply for the Sliding Fee Discount, please fill in the table below. Discounts are based on family size and household income. You must submit **proof of income** within 30 days from the date of service or the date on this form.
We will tell you what your sliding fee category and discount are, and you will be eligible for this discount **for one year**.

Examples of *types* of income:
- Social Security
- Business
- Alimony
- Child support
- Disability
- Others
- Retirement
- Welfare payments

Examples of *proofs* of income:
- 4 weeks of current and consecutive pay stubs
- Current tax return
- 4 weeks of **unemployment** check stubs

If applying for the Sliding Fee Discount, please provide the information below for yourself and all persons in your household.

Name (First, Middle Initial, Last)	Sex	Relationship to you	Date of Birth	Income & Frequency	Income Type
		SELF		$	
				$	
				$	
				$	
				$	
	Family Size:		**Household Income:**	$	

The above information supplied is current and accurate to the best of my knowledge. I understand that if information provided is found to be inaccurate, any discount given may be reversed.

☐ I **AM** applying for the Discount. ☐ I am **NOT** applying for Discount. ☐ Tell me about health insurance options available to me.

Patient/Guardian Signature **X**_____ Date: _____

OFFICE USE ONLY:

Approved Date: _____	❒ Category 1	❒ Category 2	❒ Category 3	❒ Category 4	❒ Full Pay
Usual Medical Fee:	❒ $30	❒ 40%	❒ 60%	❒ 80%	❒ Full Pay
Basic Dental Payments:	❒ $40	❒ 50%	❒ 65%	❒ 80%	❒ Full Pay
Major Dental Payments:	❒ $40+	❒ 60%	❒ 75%	❒ 90%	❒ Full Pay

Based on POI of $_____ ❒ monthly ❒ annually ❒ refused
Staff Name: _____ Date: _____

Reviewed by: Front Office Supervisor or Authorized Designee * Verification and Approval is reflected with initials, date and category directly on the income (subject to additional review).

Updated 4/1/2021