GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

FOR OFFICE USE - PATIENT NOTIFICATION

☐ **APPROVAL** ☐ **DENIAL** Expires:_____

Sliding Fee Category & Discount: _____/_____

Income Information & Sliding-Fee Discount Application

Part 1: FOR ALL PATIENTS

Thank you for providing this information, which helps us meet requirements of the federal and state grants we receive. Please find your family size, then follow that row across and circle the level closest to your **gross annual household income.**

Family Size	Income up to	Income between	Income between	Income between	Income above
1	$12,880	$12,881-$17,774	$17,775-$21,896	$21,897-$25,760	$25,761
2	$17,420	$17,421-$24,040	$24,041-$29,614	$29,615-$34,840	$34,841
3	$21,960	$21,961-$30,305	$30,306-$37,332	$37,333-$43,920	$43,921
4	$26,500	$26,501-$36,570	$36,571-$45,050	$45,051-$53,000	$53,001
5	$31,040	$31,041-$42,835	$42,836-$52,768	$52,769-$62,080	$62,081
6	$35,580	$35,581-$49,100	$49,101-$60,486	$60,487-$71,160	$71,161
7	$40,120	$40,121-$55,366	$55,367-$68,204	$68,205-$80,240	$80,241

PART 2: SLIDING-FEE DISCOUNT APPLICATION (All are welcome to apply.)

You may qualify for a discount if your household income is **less than** the amount listed for your family size in this column.
To apply, please provide the information below for everyone in your household, and attach proof of income.

Name (First, Middle Initial, Last)	Sex	Relationship to you	Birthdate	Income & Frequency	Income Type
		SELF		$	
				$	
				$	
				$	
				$	
Number of people in household:			**Annual Income:**	$	

You must submit proof of income within 30 days from the date of service or the date on this form. We will then determine your discount, which will be in effect **for one year**. Please provide proof of each type of income that any member of your family receives.
These are accepted proofs of income:

- 4 weeks of current, consecutive pay or unemployment stubs
- Current tax return
- Court documents for child support or alimony
- Retirement or pension documents
- Approval letters documenting Social Security, SSI, SSDI, TANF or other public assistance.

❒ If you have no income or do not have the types of proof listed above, please check this box. A staff member will contact you to discuss.

Part 3: FOR ALL PATIENTS

❒ I **AM** applying for the discount. ❒ I am **NOT** applying for the discount. ❒ I'd like an appointment to discuss insurance options.

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.

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

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Approved Date: _____ ❒ Category 1 ❒ Category 2 ❒ Category 3 ❒ Category 4 ❒ Full Pay

Based on POI of $ _____ ❒ monthly ❒ annually ❒ refused

Staff name: _____Date: _____

Updated December 2021