MID-STATE
HEALTH CENTER

SLIDING FEE SCALE APPLICATION

Applying for: _____ Medical _____Dental _____ Both

The Sliding Fee Scale Program is open to all New Hampshire residents having financial troubles. Those patients who qualify will pay a small fee based on their income and may have smaller office visit copays. We will review each application and in some instances, apply the new fee to past office visits. We cannot apply new fees to accounts that are in collections.

The Sliding Fee Scale Program covers most of the health center services including primary care, behavioral health, recovery services, radiology, and basic dental work such as preventive exams, simple restorative services, and emergency treatments. The program does not apply to complex or elective dental work.

The Sliding Fee Scale Program does **NOT** cover Department of Transportation (DOT) physicals ("form physicals"), Impaired Driver Care Management Program (IDCMP), Physical/Occupational Therapy services, or any fees for late-cancellations or no-shows

To see if you qualify, please return this completed application to Mid-State Health Center. Forms are not "complete" unless they include the following:

1. A copy of your most recent IRS Income Tax Return.
2. A copy of your last four (4) pay stubs from your current employer.
    a. If you are not employed, submit a notarized letter stating your last day of work and how you are supporting yourself.
3. A copy of any Social Security/ Disability Insurance (SSDI), Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP) or Medicaid letters sent to you by the State of New Hampshire.
4. A copy of your last three (3) months of bank statements for **all accounts** owned by you either individually or jointly. Include **all pages** of each statement.
5. A copy of your housing expense:
    a. If you own a home, submit 1.) Current mortgage statement showing the monthly payment and loan balance, **<u>and</u>** 2.) Current tax bill with assessed value of home.
    b. If you rent, submit current rent receipt, cancelled check, or lease agreement.

Failure to keep account balances current may result in denial of application and/or renewal.
Should you have any questions regarding the application or this program, please contact one of our Patient Account Representatives by calling (603) 238-3586.

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1. PATIENT INFORMATION

Last Name	First Name	M.I.	Social Security Number	Date of Birth
Street Address		City	State	Zip
Home Telephone	Work Telephone	Marital Status:	☐ Single/Unmarried	☐ Married

2. PAYER INFORMATION

Last Name	First Name	M.I.	SSN	Relationship to Patient
Address (If Different than Patient's)		Home Telephone		Work Telephone
Name of Insurance Company		Effective Date of Policy		

3. HOUSEHOLD OCCUPANTS (Please indicate all people living in the home, including the applicant.)

Name	Relationship to Patient	SSN	DOB	Primary Care Provider
	SELF			

4. HOUSEHOLD DEMOGRAPHICS

Have you applied for financial help at another facility? ☐ Yes ☐ No Where? ____________

Is this application for future or past services? ☐ Future ☐ Past When? ____________

Has anyone in your household applied for Medicaid? ☐ Yes ☐ No Who? ____________

When? ____________ Status? ☐ Pending ☐ Denied Reason? ____________

Is anyone in your household pregnant? ☐ Yes ☐ No Who? ____________

Has anyone in your household served in the military? ☐ Yes ☐ No Who? ____________

Have you filed a workers' compensation claim recently? ☐ Yes ☐ No When? ____________

Is anyone in your household eligible for social security? ☐ Yes ☐ No Who? ____________

Is anyone in your household covered by health insurance? ☐ Yes ☐ No Who? ____________

Name of Insurance? ____________

Does anyone else claim you on their income tax return? ☐ Yes ☐ No Who? ____________

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5. HOUSEHOLD INCOME

	Person One	Person Two	Person Three
Name of Each Household Member			
Name of Employer			
Monthly Income from:			
Employment	$	$	$
Self-Employment	$	$	$
Unemployment Benefits	$	$	$
Investments	$	$	$
Real Estate Rentals	$	$	$
Retirement Benefits (Social Security, Pension, Annuity)	$	$	$
Alimony/Child Support	$	$	$
Public Assistance (EBT/Food Stamps, TANF)	$	$	$
Other Income	$	$	$

Optional information that may be needed for financial assistance at external agencies such as Speare or Dartmouth.

***Savings and Investments in:**			
Checking Account Balances	$	$	$
Savings and CD Account Balances	$	$	$
IRAs, 403B, 401K	$	$	$
Other Savings/Investments Income	$	$	$
***Other Assets:**			
Value of Automobile	$	$	$
Year, Make, and Model			
Value of Recreational Vehicle	$	$	$
Year, Make, and Model			

6. HOUSEHOLD EXPENSES

Primary Residence Monthly Rent or Mortgage Payment: $ ______ Annual Property Tax: $ ______

Secondary Residence Monthly Rent or Mortgage Payment: $ ______ Annual Property Tax: $ ______

Monthly loans can be car loans, school loans, credit card payments, and other kinds of loans.

Monthly Loan Payment: $ ______ Paid to: ______

Monthly Loan Payment: $ ______ Paid to: ______

Monthly Loan Payment: $ ______ Paid to: ______

Monthly Utilities (electricity, heat):	$	Monthly Car Insurance:	$
Monthly Healthcare Payment Plans:	$	Monthly Renters Insurance:	$
Monthly Prescription Medications:	$	Monthly Health Insurance:	$
Monthly Child Support/Alimony:	$	Monthly Childcare/Daycare:	$
Monthly Gasoline:	$	Monthly Food/Groceries:	$
Monthly Clothing/Shoes:	$	Car Repairs/Maintenance:	$

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7. OTHER COMMENTS (Additional information you would like us to consider with your application)

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8. ASSIGNMENT OF RIGHTS (Please read this section carefully)

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete, or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of any medical, financial, or employment information which relates directly to their healthcare or to their financial assistance eligibility. This information may be released to any healthcare providers or entities from whom household members have sought healthcare services or financial assistance. All information provided will remain confidential under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). Elective procedures may not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application (for example, insurance payments, government program payments not including lawsuit payments, etc.).

If I receive Financial Assistance, then I agree to tell the organization where I first applied of any changes which could impact my eligibility, including changes to my family size, income, or health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, then I will need to apply to that program and provide proof of application.

______________________________________ ______________________________________

Applicant Signature Date Co-Applicant Signature Date

Thank you for completing all four pages of the Sliding Fee Scale application. Be sure to include your supporting documentation before submitting the completed packet to Mid-State Health Center.