



Where your care comes together.

SLIDING FEE SCALE APPLICATION

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 applications 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 basic dental work such as preventive exams, simple restorative services, and emergency treatments. The program does not apply to complex or elective dental work.

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, **and** 2.) Current tax bill with assessed value of home.
 - b. If you rent, submit current rent receipt, cancelled check, or lease agreement.

The Sliding Fee Scale Program does NOT cover Department of Transportation (DOT) physicals ("form physicals") or any fees for late-cancellations or no-shows. **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 a Patient Account Representative by calling (603) 238-3586.



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Applying for: ___ Medical ___ Dental ___ Both

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: <input type="checkbox"/> Single/Unmarried <input type="checkbox"/> 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 Spcare 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:	\$ _____

