

The Sliding Fee Scale Program offers assistance to patients experiencing financial difficulties. Those who qualify will pay a discounted fee based on their income and may have smaller office visit copays. We will review each application may be able to 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 health center services including primary care, behavioral health, recovery services, radiology, and dental work such as preventive exams, simple restorative services, and emergency treatments, as well as endodontic services.

The Sliding Fee Scale Program does **NOT** cover Department of Transportation (DOT) physicals (“form physicals”) or any fees for late-cancellations or no-shows. Fees for third party services, such as external laboratories, or other services outside of Mid-State apply separately and are not covered under the Sliding Fee Program.

This application, and the documents requested, will help Mid-State determine your eligibility. Eligibility will be determined upon receipt of completed application and accompanying documentation.

1. A copy of your most recent IRS Income Tax Return.
2. Copies of one month of pay stubs (i.e. two paystubs if you’re paid bi-weekly, four paystubs if you’re paid weekly).
 - 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 most recent bank statement.

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. Kindly inform our staff of any changes to your provided information.

Availability of Translation: Mid-State Health Center offers translation services for forms and services. Please call 603-536-4000.



1. PATIENT INFORMATION

Form for patient information including fields for Last Name, First Name, M.I., Social Security Number, Date of Birth, Street Address, City, State, Zip, Home Telephone, Work Telephone, and Marital Status (Single/Unmarried, Married).

2. PARTY RESPONSIBLE FOR PAYMENT

Form for party responsible for payment including fields for Last Name, First Name, M.I., SSN, Relationship to Patient, Address (If Different than Patient's), Home Telephone, Work Telephone, Name of Insurance Company, and Effective Date of Policy.

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

Table for household occupants with columns for Name, Relationship to Patient, SSN, DOB, and Primary Care Provider. Includes a row for 'SELF'.

4. HOUSEHOLD DEMOGRAPHICS

Form for household demographics with various questions and checkboxes (Yes/No) and fields for 'Where?', 'When?', 'Who?', and 'Reason?'.



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 SECTION FOR EXTERNAL ASSISTANCE

**Information that may be necessary for financial assistance at external agencies like Speare or Dartmouth. While we can share this information with these agencies, please note that they may require further documentation according to their respective policies.*

***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	_____	_____	_____

Other documentation that may be needed:

- **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.
- **A copy of your housing expenses**, including your current mortgage statement showing the monthly payment and loan balance AND current tax bill with assessed value of home; if you rent, your current rent receipt, cancelled check, or lease agreement.

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:	_____



HOUSEHOLD EXPENSES cont.

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:	\$ _____
	_____		_____

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

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 void 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 to my financial status, including changes to my family size or income.

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.