WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

Sliding Fee Discount Program Application

Thank you for choosing White Mountain Community Health Center as your healthcare provider. We offer a sliding fee scale that discounts the cost of our services to patients with qualifying household incomes.

Things to know about our sliding fee discount program:

- You must apply for the sliding fee discount program once a year, or by the review date on your sliding fee discount program card.
- Both uninsured and insured patients may apply. If you are insured, you will receive discounts on your deductible, copayments, and dental care.
- Uninsured patients are strongly encouraged to meet with a member of our care coordination team, who can help you find affordable health coverage. Contact one of them at the number below, or ask if they are available if you are here for an appointment.
- Our sliding fee scale gives you and anyone included in your application a discount on all of our services.
- When we send your labs out to NorDx, or your provider refers you for services at Memorial Hospital, these organizations will also honor our sliding fee scale by providing the same discount on their services that we do.

You must include documents to support every source of income you list on your application. If your household has no income, please fill out the Zero Income Worksheet for every adult household member.

Please do not submit original documents. We can make copies for you.

You can submit your completed application at the front desk during our business hours, Monday through Friday from 8 am to 4 pm. Or, you can mail your application to White Mountain Community Health Center, 298 White Mountain Hwy, Conway, NH 03818.

If you have any questions or need help filling out your application, we are here for you!
Ask to talk to someone on the Care Coordination Team if you're here already.
Call us at (603) 447-8900 to schedule an appointment with Cheryl or Erin.

Or contact one of them directly:

Care Coordinator Cheryl Frankowski – (603) 986-9753 (call or text)
cfrankowski@whitemountainhealth.org

Community Health Worker Erin White – (603) 558-0475 (call or text)
ejones@whitemountainhealth.org

Sliding Fee Scale

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	Fee Scale Level	1	2	3	4	5
COST	Medical, Behavioral & Nutrition Visits	$10	$25	$35	$50	None
	Non-provider Visits	$5	$10	$15	$20	None
	Dental Hygiene	$25	$35	$45	$55	None
	NorDx Labs	20% of cost	30% of cost	40% of cost	50% of cost	None
	X-Rays and Dentist Visits	20% of cost	30% of cost	40% of cost	50% of cost	None
	Medications Through 340b*	$2 + cost	$4 + cost	$6 + cost	$8 + cost	$10 + cost

Family Size	% of FPL Range	0 - 100%	101 - 138%	139 - 168%	169 - 200%	201% +
1	Yearly	$ - $ 15,060	$ 15,061 $ 20,783	$ 20,784 $ 25,301	$ 25,302 $ 30,120	$ 30,121 +
	Monthly	$ - $ 1,255	$ 1,256 $ 1,732	$ 1,733 $ 2,108	$ 2,109 $ 2,510	$ 2,511 +
2	Yearly	$ - $ 20,440	$ 20,441 $ 28,207	$ 28,208 $ 34,339	$ 34,340 $ 40,880	$ 40,881 +
	Monthly	$ - $ 1,703	$ 1,704 $ 2,351	$ 2,352 $ 2,862	$ 2,863 $ 3,407	$ 3,408 +
3	Yearly	$ - $ 25,820	$ 25,821 $ 35,632	$ 35,633 $ 43,378	$ 43,379 $ 51,640	$ 51,641 +
	Monthly	$ - $ 2,152	$ 2,153 $ 2,969	$ 2,970 $ 3,615	$ 3,616 $ 4,303	$ 4,304 +
4	Yearly	$ - $ 31,200	$ 31,201 $ 43,056	$ 43,057 $ 52,416	$ 52,417 $ 62,400	$ 62,401 +
	Monthly	$ - $ 2,600	$ 2,601 $ 3,588	$ 3,589 $ 4,368	$ 4,369 $ 5,200	$ 5,201 +
5	Yearly	$ - $ 36,580	$ 36,581 $ 50,480	$ 50,481 $ 61,454	$ 61,455 $ 73,160	$ 73,161 +
	Monthly	$ - $ 3,048	$ 3,049 $ 4,207	$ 4,208 $ 5,121	$ 5,122 $ 6,097	$ 6,098 +
6	Yearly	$ - $ 41,960	$ 41,961 $ 57,905	$ 57,906 $ 70,493	$ 70,494 $ 83,920	$ 83,921 +
	Monthly	$ - $ 3,497	$ 3,498 $ 4,825	$ 4,826 $ 5,874	$ 5,875 $ 6,993	$ 6,994 +
+ family member, add..	Yearly	$ - $ 5,380	$ 5,381 $ 7,424	$ 7,425 $ 9,038	$ 9,039 $ 10,760	$ 10,761 +
	Monthly	$ - $ 448	$ 449 $ 619	$ 620 $ 753	$ 754 $ 897	$ 898 +

The nominal fees for medical, behavioral, nutrition, and dental visits include all time spent with staff during a single visit and any in-house lab fees. The one exception: when a state-supplied vaccine isn't available and an uninsured patient would like to get a vaccine purchased by the Health Center instead, they will be charged the full cost.

We exist to make sure everyone in our community can access the healthcare they need. **If the sliding fee scale fees you are charged make it hard for you to access care, please ask at the front desk to talk to someone about your situation.**

*This typically applies to birth control such as an IUD or implant provided in-house, which are often a fraction of the cost when purchased through 340B.

FPL numbers were obtained from https://aspe.hhs.gov/poverty-guidelines. This sliding fee scale will be updated annually to reflect current FPL numbers.
Approved by the White Mountain Community Health Center Board of Directors on January 25, 2024.

SLIDING FEE SCALE APPLICATION

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APPLICANT INFORMATION

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH _____

PHONE NUMBER WITH AREA CODE _____ EMAIL ADDRESS _____

Do you have health insurance? ☐ No ☐ Yes – insurance company:_____

Have you applied for NH Medicaid or MaineCare? ☐ No ☐ Yes ☐ Yes, but denied coverage

HOUSEHOLD INFORMATION

Total number of household members (people you would include on your taxes, listed below)**: _____**

Please list yourself, spouse, and all dependents below. (Add any additional on back):

Name: _____ Age: ____ Patient? ☐ Y ☐ N / Relationship to self: Me

Name: _____ Age: ____ Patient? ☐ Y ☐ N / Relationship to self: _____

Name: _____ Age: ____ Patient? ☐ Y ☐ N / Relationship to self: _____

Name: _____ Age: ____ Patient? ☐ Y ☐ N / Relationship to self: _____

Name: _____ Age: ____ Patient? ☐ Y ☐ N / Relationship to self: _____

HOUSEHOLD INCOME

Adjusted gross income on most recent taxes filed: $_____ **Tax year: _____**

Please complete this table to report all current sources of income for household members 18 and older.

Income listed is (circle one): Annual Monthly Weekly			
INCOME SOURCE	**Person 1** Name:	**Person 2** Name:	**Person 3** Name:
Employment	$	$	$
Self-employment	$	$	$
Unemployment benefits	$	$	$
Retirement or pension	$	$	$
Social security	$	$	$
Disability (don't include SSI)	$	$	$
Rental or royalty income	$	$	$
Other Income	$	$	$
TOTAL	**$**	**$**	**$**
Or attach zero income form	☐ No income	☐ No income	☐ No income
Documentation included with every income source?	☐ All documents are attached	☐ All documents are attached	☐ All documents are attached

Total Income:

$

By signing:

- I certify that all information I have submitted is true and complete.
- I agree to notify White Mountain Community Health Center of any changes to my income, household, or insurance status.
- I understand that I must reapply for the sliding fee scale by my review date.
- I understand that I must pay my discounted Sliding Fee Scale amount when I am at the health center for the service, with the exception of lab charges from Nordx, which will be billed separately.
- I understand that if I am found to be eligible for reduced fees but do not make the required payments, I must talk to the billing office about my situation and create a plan with them, or my account may be sent to a collection agency.

Applicant's signature: _____ Date: _____

OFFICE USE ONLY

Proof of income verified by: _____ (staff signature) _____ date.

SFDP Determination: FS1 FS2 FS3 FS4 Not qualified ☐ **Chart updated**

Notification provided by: _____ (staff initials) _____ date. ☐ **Registry updated** ☐ **Letter sent**

Eligible for marketplace coverage? ☐ yes ☐ no **Status**: ☐ declines ☐ will apply ☐ application pending ☐ application denied

ZERO INCOME WORKSHEET

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Name of person with no income _____ Date of birth: _____

I, _____certify that I have not received any income since _____ (date).

My last place(s) of employment were: _____

☐ I am a full-time student over the age of 18. Attach copy of student ID

☐ I am a full-time stay-at-home parent of child(ren) under 5. Child's name and age: _____

I live in:

- ☐ My own home/apartment Do you receive housing assistance? ☐ Yes ☐ No If yes, attach documentation
- ☐ Someone else's home/apartment – Name of house/apartment owner: _____
- ☐ Shelter/Transitional housing
- ☐ Other: _____

Do you receive SNAP benefits? ☐ Yes If yes, attach documentation ☐ No

Transportation: ☐ I have my own vehicle ☐ A friend or relative drives me ☐ I use public transportation

Do you have a cell phone? ☐ Yes ☐ No If yes, who pays for your cell phone? _____

Fill out this chart with your expenses for the last three months. If anyone has helped you with expenses during these three months, please have them sign the back of this form. This includes paying for the expense directly, giving you money to pay for the expense, or giving you the needed service for free.

3-MONTH LIVING EXPENSE REPORT	**Month: (example)** January		**Month:**		**Month:**		**Month:**	
Type of expense	**Cost**	**Who paid?**	**Cost**	**Who paid?**	**Cost**	**Who paid?**	**Cost**	**Who paid?**
Housing	Free	Mom						
Water and/or electric	Included	Mom						
Heat	Included	Mom						
Food	$150	SNAP						
Transportation	$25	Grandma						
Phone/internet	$40	Mom						
Medical	none	N/A						
Other	none	N/A						

Name(s) and signature(s) of those who provided assistance must be provided on reverse side of this form.

Please turn form over and complete the second side

People who helped you with expenses in the last three months:

Name: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____

Important things to know:

- This form must be filled out completely; we will not be able to process your application if you leave parts of it blank.
- If you need to tell us more about your situation, please feel free to attach a letter or statement to this worksheet, or schedule a meeting with one of our care coordinators.
- If you receive assistance from other agencies, such as DHHS or your town, please attach copies of any paperwork verifying the assistance provided to you.

Name of organization or agency who provided you with assistance: Please also attach documentation

_____ Date: _____

By signing below, I attest that I have no income, and:

- I have read or have had read to me the above worksheet and that all of the information I supplied is correct.
- I understand that failure to fully disclose my true income is considered an act of fraud, which is punishable by law. I give White Mountain Community Health Center permission to investigate the information provided in this application.
- I understand that, if approved, this declaration of zero income will only be valid for a total of 6 months, after which time I will need to renew my application. (Exceptions: full-time students are valid for the lesser of 3 months after the Student ID expiration date or 12 months. Full-time stay-at-home parents of children under 5 are valid for 12 months.)
- I also understand that if my income changes, I am required to notify the Health Center and may be required to complete an updated application.

I certify that all the information above is true and correct.

Signature: _____ Date: _____

Name of Sliding Fee Scale applicant, if different from above: _____

Office use only

Date received: _____

Supporting documents attached? ☐ Yes ☐ N/A ☐ No - return application to patient

Billing staff verified (initials and date): _____

Expiration date, if qualified: _____

Care Coordinator reviewed (initials and date): _____

Form updated 11/30/2022 jeh