SLIDING FEE DISCOUNT PROGRAM APPLICATION

Thank you for choosing Amoskeag 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:

- Eligibility for the sliding fee discount program is based solely on household income and family size.
- An application must be completed in full to determine eligibility and you must reapply by the end date on your program card
- Both uninsured and insured patients with cost sharing (i.e. high deductibles, copayments) are eligible to apply.
- Uninsured patients are strongly encouraged to meet with a member of our case management team or patient access team who can assist with finding affordable health coverage.
- Elliot Hospital and Catholic Medical Center will honor our sliding fee discount program card, patients must contact those organizations to determine costs.

You must include documents to support every source of income you list on your application, examples include:

- Complete copy of most recent Federal Income Tax return or most recent W-2 or 1099 form. Self-employed individuals must include all schedules with their tax return.
- Copy of last (4) most recent consecutive paystubs if paid weekly or (2) if paid bi-weekly.
- If paid in cash a letter from employer stating number of hours worked, hourly wage, and how often paid.
- Copy of unemployment or disability benefit statement
- Copy of social security, disability, supplemental income and pension benefit statements
- Documentation of other governmental assistance

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

If your household has no income, please complete the Zero Income Worksheet for every qualifying adult household member.

You can submit your completed application at any Amoskeag Health location during normal business hours, Monday through Friday 8am to 5pm. Or you can mail your application to Amoskeag Health, 145 Hollis St. Manchester, NH 03101, Attn: Patient Access department.

If you have any questions or need help filling out your application, we have staff available to assist you Monday through Friday 9am to 2pm at our 145 Hollis St. location.

SLIDING FEE SCALE APPLICATION

AMOSKEAG HEALTH

APPLICANT INFORMATION

FIRST NAME LAST NAME DATE OF BIRTH

STREET ADDRESS CITY/STATE/ZIP CODE PHONE NUMBER

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

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

HOUSEHOLD INFORMATION

Total number of household members: _____

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

Name:_____ DOB:_____ Relationship: Applicant/Self

Name:_____ DOB:_____ Patient? ☐ Y ☐ N / Relationship: _____

Name:_____ DOB:_____ Patient? ☐ Y ☐ N / Relationship: _____

Name:_____ DOB:_____ Patient? ☐ Y ☐ N / Relationship: _____

Name:_____ DOB:_____ Patient? ☐ Y ☐ N / Relationship: _____

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	**$**	**$**	**$**
Self-Emloyment	**$**	**$**	**$**
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 all income sources?	☐ All documents attached	☐ All documents attached	☐ All documents attached

By Signing:

- I certify that all information I have submitted is true, and I am authorizing Amoskeag Health to verify that information, and release it to referring/mutual providers of care.
- I agree to allow Amoskeag Health to share demographic and income information data with City, State, Federal and Private grantors as necessary.
- I understand that I am financially responsible for all bills for services prior to completion and acceptance of this application and if my application is denied.
- I understand that I must pay my discounted Sliding Fee Scale amount when I am at the health center for services if my application has been approved.
- I agree to notify Amoskeag Health of any changes to my income, household, or insurance status.
- I understand that I must reapply for the sliding fee scale by my end date.
- I understand that Amoskeag Health is regulated by policies and regulations by the federal government, and it is considered unlawful to misrepresent or falsely claim inaccurate information on this application.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Spouse/Partner (if applicable) Date

OFFICE USE ONLY

Total # Household Members: _____ Total Household Income: $_____ (Weekly) $_____ (Annually)

DISCOUNT: ☐ Approved-Annual ☐ Approved-6 Months ☐ Approved 30-day Temporary

☐ Denied – Reason_____

PERIOD OF COVERAGE: Effective Date: ____/____/_____ Expiration Date: ____/____/_____

THIRD PARTY PAYOR IF APPLICABLE:_____

DISCOUNT ASSIGNMENT: 1 2 3 4 5 6-Self-pay CUCF

Staff Signature: _____ Staff Name: _____

ZERO INCOME WORKSHEET

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

I, _____ declare that I have no source of income.

I live in:

☐ My own home/apartment Do you receive housing assistance? ☐ No ☐ Yes, if yes attach documentation

☐ Living with relative(s) or friend – Name of person living with: _____

☐ Shelter/Transitional housing

☐ Other: _____

Do you receive public assistance (SNAP, TANF, Childcare, etc.): ☐ No ☐ Yes, if yes attach documentation

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 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 LVING 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	Son						
Water and/or Electric	Included	Son						
Heat	Included	Son						
Food	$150	SNAP						
Transportation	$25	Son						
Phone/Internet	$40	Son						
Medical	None	N/A						
Other	None	N/A						

Name(s) and signature(s) of those who provided assistance must be provided below.

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 patient access staff.
- 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.

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 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 Amoskeag Health permission to investigate the information provided in this application.
- I understand that, if approved this declaration of zero income will only be valid for 6 months, after which time I will need to renew my application.
- 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: _____

Office Use Only

Date received: _____

Supporting documents attached: ☐ Yes ☐ N/A ☐ No – return application to patient