HealthFirst

"Health care for the wholefamily"

841 Central Street, Franklin, NH 03235 P: (603) 934-1464 F: (833) 949-3968
22 Strafford Street, Laconia, NH 03246 P: (603) 366-1070 F: (833) 949-3973
18 Roberts Road, Canaan, NH 03741 P: (603) 523-4343 F: (833) 449-2582

Get affordable healthcare today!

HealthFirst Sliding Fee Scale (SFS) Discount Program

HealthFirst offers a program to help. The SFS Discount Program provides adjusted fees on medical and behavioral health services at our facilities based on your income and household size.

Here's what you need to know:

- **Who qualifies:** Uninsured or underinsured patients
- **What's covered:** HRSA-approved services at HealthFirst (excluding hospital labs, dental services, and DOT exams)
- **How much discount:** Varies based on your income
- **How to apply:**
  - Complete the application
  - Include proof of income (see application for details)
  - Return by mail to one of our addresses or by email to the listed contacts
- **Discount details:**
  - Applied to co-pays after insurance processes your claim
  - Valid for 1 year, reapply annually
  - Not insurance, doesn't cover outside services
  - Applies retroactively for 90 days on approved charges

How to Apply for the SFS Discount Program

1. Complete Application and include copies of your household income verification (see list of acceptable documents on the application; only **ONE** requested document needed)

2. Return Application & Supporting Income Documents
   - **Drop** it off at the front desk at any HealthFirst location.
   - **Mail** completed application back to HealthFirst in the enclosed self-addressed stamped envelope
   - **Email** it any HealthFirst Community Resource Specialist

If you don't qualify: our Community Resource Specialists are available to assist with arranging an affordable payment plan or navigate alternative insurance options.

Need application help? Contact our Community Resource Specialists:

- Maegan Wyatt (Franklin) (603) 934-1464 x145 mwyatt@hffcc.org
- Amanda Simonds (Laconia) (603) 366-1070 x442 asimonds@nffcc.org
- Jenn Colby (Canaan) (603) 523-4343 x550 jcolby@hffcc.org

Rev. 08-27-2024

Discount Program Application

HealthFirst Office Location

- ☐ 841 Central St. Franklin, NH 03235 (603) 934-1464
- ☐ 22 Strafford St. Laconia, NH 03246 (603) 366-1070
- ☐ 18 Roberts Rd. Canaan, NH 03741 (603) 523-4343
- ☐ 17 Church St. Laconia, NH 03246 (603) 366-7070

Applicant Information

Name:____

Physical Address:__________________________City:____________________State/zip:____________

Mailing Address (if different than above):____

Home #:____________________Cell#:_____________________Work#:___________________

Household Income

Please indicate all people living in the household (spouse, children, and other dependents you would claim on taxes), including applicant:

Name	Relationship to Applicant	Date of Birth	Monthly income	*Source of income
1)____________________	SELF	____/____/____	$__________	__________
2)____________________		____/____/____	$__________	__________
3)____________________		____/____/____	$__________	__________
4)____________________		____/____/____	$__________	__________
5)____________________		____/____/____	$__________	__________

*Sources of income include job related earnings, unemployment, workers' compensation, Social Security, veterans' payments, pensions or retirement income, rents, royalties, and other miscellaneous sources

Documents requested *Please provide **ONE** of the following

Documentation includes, but is not limited to:

- Four (4) of the most recent paystubs
- Proof of other household income (Social Security, pension, unemployment etc.)
- Current bank statements showing direct deposits
- Most recent income tax return or W-2 if no other current income proof is available
- HealthFirst Self-Declaration Form **required** for certifying zero income

Patients may request a "Self-Declaration Form" which can substitute for all requested documents.

The data gathered on this form will only be used so that we can better meet your medical and/or behavioral health needs. **This information will not be used to withhold or deny services to you.**

Applicant Signature: ____________________________________ Date: ________________

Applicant Name (Print): ____________________________________

Discount Program Application

Office Use Only: Date of Determination: ______________________ ☐ In-Office ☐ Mail/Email

Family Size: ________ Total Gross Monthly Income: _____________

☐ SFS Approved SFS Discount Level

SFS-1	SFS-2	SFS-3	SFS-4	Effective Date:	Expiration Date:	*90 Days retro:
$15	$20	$25	$30	____________	_____________	_____________

☐ SFS Incomplete ☐ Missing Income letter: ______________________ ☐ Final Notice: _________________________

☐ SFS Denied ☐ Over income ☐ Incomplete application ☐ Other: _______________________

Staff Signature: ____ Date: __________________________