HEALTHFIRST

FOR OFFICE USE ONLY

☐ APPROVED ☐ DENIED:

_____

☐ 90 days retroactive

Sliding Fee Discount Program Application

The SFS Discount provides adjusted fees on HRSA- approved medical and behavioral services at our facilities (does not cover outside services) based on your income and household size (excluding hospital labs and DOT exams). Discount can be approved for 90 days retroactive

Household Size	1 - $0 Co-Pay	2 - $5 Co-Pay	3 - $15 Co-Pay	4 - $25 Co-Pay
1	$0.00 - $1330.00	$1331.00 - $1995.00	$1996.00 - $2460.50	$2461.50 - $2660.00
2	$0.00 - $1803.33	$1804.44 - $2705.00	$2706.00 - $3336.17	$3337.17 - $3606.67
3	$0.00 - $2276.67	$2277.67 - $3415.00	$3416.00 - $4211.83	$4212.83 - $4553.33
4	$0.00 - $2750.00	$2751.00 - $4125.00	$4126.00 - $5087.50	$5088.00 - $5550.00
5	$0.00 - $3223.33	$3224.33 - $4835.00	$4836.00 - $5963.17	$5964.17 - $6446.67

PATIENT INFORMATION		
Patient Name:		
Date of Birth:		
Address:		
City:	State:	Zip:
Phone:		
Cell:		
Email:		

Please provide information below for everyone in your household and provide proof of income.				
Name (First, Middle, Last)	Relationship to applicant	Date of Birth	Income monthly	Income type
	SELF			

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PROOF OF INCOME
Please provide one or more of the following
☐ Two recent pay stubs
☐ Most recent federal tax return
☐ W-2 form
☐ Social Security award letter
☐ Unemployment benefits statement
☐ Employer letter
☐ Self-attestation (if no formal documentation available)

INSURANCE INFORMATION
Do you currently have health insurance?
☐ Yes
☐ No
If yes:
Insurance Carrier:
Member ID #:
Subscriber:

SELF-ATTESTATION (Optional)
Complete only if income documentation is unavailable. I certify that I currently have no available proof of income and that the information provided below is true and accurate to the best of my knowledge.
Explanation:

APPLICANT CERTIFICATION
I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that providing false information may result in denial of discounted services. I agree to notify [Organization Name] if my income, household size, or insurance status changes.
Applicant Signature:
Date:

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Application Date:
Household Size:
Annual Household Income: $
Federal Poverty Level Percentage:
Discount Level Assigned
Effective Date:
Expiration Date:
Staff Initials:

Please contact HealthFirst CRS for any questions or concerns.

Franklin: 603-934-1464 Laconia: 603-366-1070

asimonds@hffcc.org