SLIDING FEE DISCOUNT PROGRAM APPLICATION - INSTRUCTIONS

Thank you for choosing Amoskeag Health Center as your healthcare provider. We offer a sliding fee scale program that discounts the cost of Amoskeag Health services to patients that may not be able to pay for them. The sliding fee program gives discounts to eligible patients with qualifying household incomes.

To determine eligibility for the sliding fee discount card, applicant(s) are required to fully complete an application; all parts of the application must be completed, dated and signed. **Incomplete applications will not be accepted**. If an application is not complete, the applicant will be sent a request for more information; additional information must be received within 10 days, or the application will be denied.

Please follow these Instructions when completing the application:

1. Applicants may apply for themselves or their whole family. The family size and income must include all family members unless the application is for a financially independent individual.
2. Street address – this is the address where you and your family live
3. Members of the household – this means the head of household, spouse, children, and all other dependents included on your most recent tax return.
4. Please tell us if anyone is covered by health insurance
5. The application must be signed and dated before it is turned in for review.
6. Proof of Income – **You must include Income documentation to support every source of income you list on your application, examples include:**
   - Self-employed applicants must submit a completed copy of most recent Federal Income Tax return, 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 you are paid in cash you must complete the self-declaration form attached to the application.
   - Copy of unemployment or disability benefits statement
   - Copy of Social Security, disability, supplemental income or pension benefit statements
   - Documentation of other governmental assistance.

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.

Your application will be processed within 2 business days after completed application received, **all incomplete applications will be returned.**

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

SLIDING FEE SCALE APPLICATION

Application is for: _____ Individual _____ Family Date of Application: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone:_____

Total number of household members: _____

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

NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT	GENDER Male/Female	EMPLOYED Yes/No
		Applicant/Self		

Does anyone in the household have health insurance? No Yes – Insurance Name:_____

Have you applied for NH Medicaid? No Yes **(if denied coverage must provide denial letter from Medicaid)**

Declaration on No Income (if you have no source of income please complete)

I, _____, declare that I have no source of income
Print Name

I, _____, declare that I have no source of income
Print Name

Please explain how you pay your current monthly living expenses such as rent, food, gas, clothing etc. This includes paying for the expense directly, giving you money for the expense, or giving you the needed service for free. Please provide the name, relationship of those who have provided assistance with expenses and have them sign below.

Name: _____ Relationship: _____

Signature of person providing assistance: _____ Date: _____

Name: _____ Relationship: _____

Signature of person providing assistance: _____ Date: _____

- You must answer every question. If something does not apply to you put N/A in that space. You must sign and date the application prior to submitting. If you do not sign the application your application will be denied.
- If you need to tell us more about your situation, please feel free to attach a letter or statement to this application or schedule a meeting with one of our Patient Access staff.

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 on my card.
- 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

OFFICE USE ONLY

Date Application received: _____ Name of Staff receiving Application: _____

Last Date Patient Was Seen: _____ Income Verification Provided: _____

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: ____/____/_____

INSURANCE THIRD PARTY PAYOR IF APPLICABLE:_____

DISCOUNT ASSIGNMENT: 1 2 3 4 5 6-Self-pay CUCF (If applicable)

Staff Initials performing eligibility review: _____ Date Notification/card given/mailed to patient: _____

AMOSKEAG HEALTH

SELF-DECLARATION OF CASH INCOME EARNED (Separate form must be completed for each applicant in the household that receives cash income)

FIRST NAME LAST NAME DATE OF BIRTH

STREET ADDRESS CITY/STATE/ZIP CODE PHONE NUMBER

PLEASE INCLUDE THE MOST RECENT CONSECUTIVE 4 WEEKS OF CASH INCOME EARNED:

DATE	SOURCE OF INCOME (Describe)	$ AMOUNT RECEIVED

"I, (print patient/applicant name)_____, hereby declare under the penalty of perjury and the laws of the United States of America that the information provided above is true and correct and this is an accurate statement of my cash earnings during the time period indicated above. Furthermore, I understand that failure to provide accurate information regarding my financial status may result in the termination of my sliding fee discount services at Amoskeag Health. I also understand that I may be prosecuted for fraud."

_____ _____

Patient/Applicant Signature Date

_____ _____

Staff/Witness Signature Date