GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First — support for families...health care for all

FOR OFFICE USE - PATIENT NOTIFICATION
☐ **APPROVAL** ☐ **DENIAL**
Sliding Fee Category & Discount: _____/_____
Expires:_____

SLIDING FEE DISCOUNT APPLICATION

Greater Seacoast Community Health offers a discount based on income for patients who are uninsured, or whose insurance doesn't cover certain services (such as dental or behavioral health care).

IF YOU DO NOT WISH TO APPLY: Please provide the information and signature requested below. This helps us meet the requirements of the state and federal grants we receive. Family size:_____ Annual household income: $_____

☐ I do not wish to apply for the sliding fee discount. Patient/guardian signature: _____ Date: _____

TO APPLY FOR THE SLIDING FEE DISCOUNT: Please fill in the table below and supply proof of income within the next 30 days. Discounts are based on family size and household income. We will tell you what your sliding fee category and discount are, and you will be eligible for this discount for one year. (After one year, you will be asked to submit proof of income again.)

Examples of *types* of income:
- Social Security
- Retirement
- Business
- Welfare payments
- Child support
- Alimony
- Disability
- Others

Examples of *proofs* of income:
- 4 weeks of current and consecutive pay stubs
- Current tax return
- 4 weeks of unemployment check stubs

Please provide the information requested below for yourself and all persons living with you.

Name (First, MI, Last)	Sex	Relationship to you	Date of Birth	Income and Frequency	Income Type
		SELF		$	
				$	
				$	
				$	
				$	
	Family Size:		Household Income:	$	

The above information supplied is current and accurate to the best of my knowledge. I understand that if information provided is found to be inaccurate, any discount given may be reversed.

Patient/Guardian Signature X_____Date:_____

☐ I would like a free appointment to understand the insurance options available to me.

OFFICE USE ONLY:

Approved Date: _____	❒ Category 1	❒ Category 2	❒ Category 3	❒ Category 4	❒ Full Pay
Usual Medical Fee:	❒ $30	❒ 40%	❒ 60%	❒ 80%	❒ Full Pay
Basic Dental Payments:	❒ $40	❒ 50%	❒ 65%	❒ 80%	❒ Full Pay
Major Dental Payments:	❒ $40+	❒ 60%	❒ 75%	❒ 90%	❒ Full Pay

Based on POI of $_____ ❒ monthly ❒ annually ❒ refused

Staff Name: _____ Date: _____

Reviewed by: Front Office Supervisor or Authorized Designee * Verification and Approval is reflected with initials, date and category directly on the income (subject to additional review).