Community Health Center of the North Country

Sliding Fee Discount Application 2026

Patient Name *(Fill out this section)*		**Responsible Person** *(Income & Employment Info Required)*		**Today's Date** / /
First Name:	Middle:	Last:	Patients Date of Birth: / /	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -		
Social Security # - -	Do you have insurance? ☐No ☐Yes	If Yes, What Insurance:		
Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed				

OTHER PEOPLE in your household:

Name	Date of Birth	Patient Relationship
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

NOTE: To comply with federal regulations, in order to give you a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Employment Income *(Responsible Person)*

Name	Amount	How Often?	Employer:
You	$	☐ Week ☐ Month ☐ Year	
Spouse	$	☐ Week ☐ Month ☐ Year	
Children	$	☐ Week ☐ Month ☐ Year	
Other	$	☐ Week ☐ Month ☐ Year	
	$	☐ Week ☐ Month ☐ Year	
TOTAL	$	☐ Week ☐ Month ☐ Year	

Other Income *(Responsible Person)*

	You	Spouse	Children	Other	How Often?
Social Security	$	$	$	$	☐ Week ☐ Month ☐ Year
Public Assistance	$	$	$	$	☐ Week ☐ Month ☐ Year
Retirement Pension	$	$	$	$	☐ Week ☐ Month ☐ Year
Disability	$	$	$	$	☐ Week ☐ Month ☐ Year
Child Support/Alimony	$	$	$	$	☐ Week ☐ Month ☐ Year
Interest Income	$	$	$	$	☐ Week ☐ Month ☐ Year
Other	$	$	$	$	☐ Week ☐ Month ☐ Year

For Office Use Only:

☐ Approved ☐ Denied

Household Size: _____

Income: _____

Patient Designation:

____ **Group A**
____ **Group B**
____ **Group C**
____ **Group D**
____ **Group E**

Authorized Signature:

_____

Date: _____

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Community Health Center of the North Country if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Community Health Center of the North Country. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Name (Please Print):_____

Signature:_____

Sliding Fee Scale Discounts According to Group Designation on Next Page

Sliding Fee Discount According to Group Designation

Eligible Services	Group A	Group B	Group C	Group D	Group E
Behavioral Health / Dermatology / Foot Care / Pediatrics / Physical Therapy / Primary Care / Women's Health	No Discount	$80	$55	$35	$20
Dental Care (Preventative Services/Emergencies)	No Discount	$80	$55	$35	$20
Dental Care (Expanded Dental Procedures) Sealants, Fillings, Periodontics, Extractions, Endodontics, Crowns, Bridges, Partials, Dentures, Prosthetic Repairs, Space Maintainers, Occlusal Guards and Hard/Soft Tissue Modifications	No Discount	10% Discount^	30% Discount^	60% Discount^	$40*

If applicable, additional out-of-pocket costs for lab fees will apply.
^Discount applied to total service fees.
Supplies, equipment and lab charges above and beyond the sliding fee charges are the patient's responsibility.
Supplies, equipment and lab charges are calculated based on cost plus administrative fees.

2026 Federal Poverty Guidelines

Household Size	Group A	Group B	Group C	Group D	Group E
Poverty Level	201%	200%	166%	133%	100%
1	31,921	31,920	26,494	21,227	15,960
2	43,281	43,280	35,922	28,781	21,640
3	54,641	54,640	45,351	36,336	27,320
4	66,001	66,000	54,780	43,890	33,000
5	77,361	77,360	64,209	51,444	38,680
6	88,721	88,720	73,638	58,999	44,360
7	100,081	100,080	83,066	66,553	50,040
8	111,441	111,440	92,495	74,108	55,720
9	122,801	122,800	101,924	81,662	61,400
10	134,161	134,160	111,353	89,216	67,080
11	145,521	145,520	120,782	96,771	72,760
12	156,881	156,880	130,210	104,325	78,440
13	168,241	168,240	139,639	111,880	84,120
14	179,601	179,600	149,068	119,434	89,800