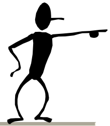
Ammonoosuc Community Health Services, Inc.
Sliding Fee Scale Discount Application (Please Print)

SLIDING FEE SCALE APPLICATION

For those patients who do not have Medical Insurance, ACHS offers a sliding fee scale discount based on Total Household Income and Total Household Size. In order to determine if you are eligible for a discount, please list all sources of income for your entire household. Proof of income is required *(see back of this page for "Proof of Income")*.



Number of people in household this supports: ____________ Please list all household members below

Name	Birth date	Relation	Employed	Name	Birth date	Relation	Employed
	/ /		☐Yes ☐No		/ /		☐Yes ☐No
	/ /		☐Yes ☐No		/ /		☐Yes ☐No
	/ /		☐Yes ☐No		/ /		☐Yes ☐No
	/ /		☐Yes ☐No		/ /		☐Yes ☐No

List each member of your household who is employed and their salary or income before taxes (after business expenses if you are self-employed):

1. ______________________________ $ ____________________ per ☐ week, ☐month, ☐year
2. ______________________________ $ ____________________ per ☐ week, ☐month, ☐year
3. ______________________________ $ ____________________ per ☐ week, ☐month, ☐year
4. ______________________________ $ ____________________ per ☐ week, ☐month, ☐year

Business and / or Rental Income $ ____________________ per ☐ week, ☐month, ☐year

Unemployment/Disability $ ____________________ per ☐ week, ☐month, ☐year

Veterans Benefits/National Guard $ ____________________ per ☐ week, ☐month, ☐year

Social Security $ ____________________ per ☐ week, ☐month, ☐year

Other Retirement Income $ ____________________ per ☐ week, ☐month, ☐year

Alimony/Child Support $ ____________________ per ☐ week, ☐month, ☐year

Interest/Dividends $ ____________________ per ☐ week, ☐month, ☐year)

Other Income (Specify)______________. $ ____________________ per ☐ week, ☐month, ☐year)

Total Gross Household Income: $ ____________________ per ☐ week, ☐month, ☐year)

(Initials)_______ I hereby declare that I do not receive any income from any source.
(Initials)_______ I do not have medical insurance and choose not to state my income and agree to pay full fee for services rendered.

I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at ACHS and referral of documents to an appropriate federal agency for further investigation.

I request ACHS to provide me and/or my family with medical care.

Name:_________________________________ **Signature:** _________________________________

Date:_________________________________

Office use only:
Monthly Total: _______________ Eligible for SFS: ☐Yes ☐No Fee Scale: _____ ☐Card Given

Eligible for PN: ☐Yes ☐No Prenatal # ____________ Services: ☐PC ☐RH ☐PN ☐Weekend Call

Reproductive Health # ____________ Home Location: ☐Littleton ☐Warren ☐Whitefield ☐Woodsville ☐Franconia

Initials: _________ Date: _____/_____/_____

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PROOF OF INCOME

Total household income must be documented when applying for the ACHS sliding fee scale. The following is a list of acceptable documentation for specific forms of income. Other forms of documentation may be accepted at the discretion of ACHS.

Employment: Three consecutive recent pay stubs.

Self-Employment: Most recent Federal tax return with all supporting schedules.

Business Income: Most recent Federal business tax return and most recent personal Federal tax return.

Unemployed: Unemployment claim determination letter.

Retirement: Social Security checks or bank statement showing direct deposits.

Statements or other official documents showing private pension, annuities or individual retirement accounts.

Disability: Social Security disability checks or bank statements showing direct deposits.

Private long or short term disability insurance checks

Alimony / Child Support Legal documents showing amounts ordered to be paid for child support and/or alimony.

Interest / Dividends: Bank and/or investment account statements.