Northland Health Centers

Sliding Fee Scale Application

Return completed form and proof of income to:
Patient Services Coordinator, NCHC Administration
PO Box 535, Turtle Lake, ND 58575-0535
email: sfs@northlandchc.org; Phone: 701-448-2054

Because we are a Federally Qualified Health Center, we have the opportunity to offer a discount on your services based on your annual income. If you feel this may be a benefit to you and your family, please complete this Sliding Fee Scale Application and attach income verification as defined below.

1. Head of Household Information:

Name: (First, middle initial, Last):	Social Security Number:	Date of birth:	County:
Mailing Address:	City/State/Zip:	Phone:	E-mail:
# of people responsible for in home:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		

2. Household Information: List ALL individuals in household, including the head of household.

First and Last Name	Date of Birth	Source of Income	M/F	Relationship
1.(Self)				
2.				
3.				
4.				
5.				
6.				

3. Income Verification: Verification of income is required. Please include one of the following. **If you have multiple forms of income verification each income source is required.** Acceptable forms of income include the following:

- Current Income Tax Document (Page 1 of Form 1040)
- Two or more current consecutive paystubs.
- Social Security benefit letter (available through the local Social Security office)
- Two or more current consecutive bank statements **ONLY IF verifying SSA or SSI direct deposit details or a direct deposit from employer.**
- Form 4506-T listing Northland Community Health Center as the third party (available here)
- Unemployment benefit letter or statement (available through the local Job Service office)
- Letter denying unemployment benefits (available through the local Job Service office)

SFS eligibility will be determined based on household size and gross annual household income (see Sliding Fee Schedule – reverse side). I agree to inform NCHC if there are changes to my household size or income. I hereby certify that the information provided above and attached is accurate and complete. **Incomplete applications will be considered "void" after 30 days.** Recertification will be required annually. By signing below, I hereby certify that I have received a copy of NCHC's Sliding Fee Scale Program Eligibility Requirements and will adhere to said requirements.

Applicant's Signature: _____ Date: _____

Guardian or Power of Attorney Signature: _____ Date: _____

☐ By checking this box, I hereby certify that I have personally submitted this data electronically, and that the data contained wihtin is true, complete, and accurate to the best of my knowledge and belief.

Internal Use Only:	
Guarantor #	
Total Income	
Effect Date	
Exp. Date	
Slide Level	
Notes	Letter
SFS Log	Card
Updated	R#

NORTHLAND HEALTH CENTER SLIDING FEE SCHEDULE

BASED ON POVERTY GUIDELINES PUBLISHED 01-13-2018

2018 YEARLY - EFFECTIVE: 04-01-2018

SFS CODE	A		B		C		D		E	
DISCOUNT PERCENTAGE	SFS DISCOUNT 100%		SFS DISCOUNT 80%		SFS DISCOUNT 60%		SFS DISCOUNT 40%		SFS DISCOUNT 20%	
FAMILY SIZE	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
1	$0	$12,140	$12,141	$15,175	$15,176	$18,210	$18,211	$21,245	$21,246	$24,280
2	$0	$16,460	$16,461	$20,575	$20,576	$24,690	$24,691	$28,805	$28,806	$32,920
3	$0	$20,780	$20,781	$25,975	$25,976	$31,170	$31,171	$36,365	$36,366	$41,560
4	$0	$25,100	$25,101	$31,375	$31,376	$37,650	$37,651	$43,925	$43,926	$50,200
5	$0	$29,420	$29,421	$36,775	$36,776	$44,130	$44,131	$51,485	$51,486	$58,840
6	$0	$33,740	$33,741	$42,175	$42,176	$50,610	$50,611	$59,045	$59,046	$67,480
7	$0	$38,060	$38,061	$47,575	$47,576	$57,090	$57,091	$66,605	$66,606	$76,120
8	$0	$42,380	$42,381	$52,975	$52,976	$63,570	$63,571	$74,165	$74,166	$84,760
9	$0	$46,700	$46,701	$58,375	$58,376	$70,050	$70,051	$81,725	$81,726	$93,400
10	$0	$51,020	$51,021	$63,775	$63,776	$76,530	$76,531	$89,285	$89,286	$102,040
% OF POVERTY LEVEL	100%		125%		150%		175%		200%	