



Instructions for completing Application for Coverage under Sliding Fee Discount Program

Lamprey Health Care offers a sliding fee discount program to help patients get health care when they may not be able to pay for them. This sliding fee discount program applies to most services we offer. The program gives discounts to eligible patients based on their ability to pay.

To determine if a patient qualifies for the program, he/she is required to fully complete an application. All parts of the application must be filled in. The application must be dated and signed. If an application is not complete, the applicant will be sent a request for more information. The patient must send us the additional information within 10 days or the application will be denied.

Please follow these instructions:

Is the application for an individual or for the whole family?

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.

Street Address – this is the address where you and your family live.

Mailing Address – this is the address where the post office delivers your mail.

Members of the Household – this means the head of household, spouse, children, and all other dependents included your most recent tax return. If someone on the application is pregnant add the baby. If the household is two people who are not married and their children, all dependents from both individuals' tax returns must be listed.

Please list all people in the family who are 18 or over in the adult section. List all children under the age of 18 in the children section.

If someone is pregnant include the due date.

Please list if anyone is disabled.

Please tell us if anyone has health insurance who is covered.

The application must be signed and dated before it is turned in for review.

Proof of Income – All family members should complete an Income Verification. Attach two months of paystubs for each job. If you don't have paystubs you can get a form for your employer to fill out for you.

Other Sources of Income – all other sources of income should be listed. This section should include the name of the person who gets the income, the source of the income, the amount regularly received and the time period the payment covers. Some examples of other income to include are unemployment, disability, workers compensation, Social Security, SSI, the value of public assistance including welfare, food stamps, and child care benefits, veteran's benefits, survivor benefits, pension or retirement income, interest, dividends, other investment income, rental income, royalties, income from trusts and estates, alimony, child support, and financial help from others outside the family.

Please include proof of income for every source of income. Proof of income might be a pay stub, a letter, a bank statement showing the deposit, or a copy of the check. The application will not be complete if you don't attach the proof.

If you have questions when you fill out the application, please call the appropriate site and you will be directed to someone who can help you.

Newmarket: 603-659-3106

Raymond: 603-895-3351

Nashua: 603-883-1626



Application for Coverage under Sliding Fee Discount Program (SFDP)

Application is for: _____ Individual _____ Family Date: _____

Last Name: _____ First name: _____

Street Address: _____

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

Mailing Address (if different): _____

City: _____ State: _____ Zip Code: _____

Adult Members of Household (please check box if individual is employed)

Name	Relationship to Applicant	Date of Birth	Gender	Primary Language

Children in the Household (please check box if individual is employed)

Name	Relationship to Applicant	Date of Birth	Gender	Primary Language

Is anyone in the household pregnant: _____ yes _____ no Due Date: _____

Is anyone in the household disabled: _____ yes _____ no Name: _____

Does anyone in the household have medical or dental insurance? _____ yes _____ no If yes, please provide a copy of the front and back of your insurance cards.

Declaration of No Income (if you have no source of income please complete, otherwise go to page 2):

I, _____, declare that I have no source of income.

Please explain how you pay your current monthly living expenses such as rent, food, gas, clothing and medical care: _____



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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 before you send it in. If you do not sign the application your application will be denied.

I certify that the above information is true and complete. I authorize Lamprey Health Care to verify any of the above information and release the above information to referring/mutual providers of care. 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 Lamprey Health Care is regulated by policies and regulations established by the federal government and it is considered unlawful to misrepresent or falsely claim inaccurate information on this application.

(signature of applicant)

(date)

FOR OFFICE USE ONLY:

Date application received: _____

Name of Staff member receiving application: _____

Assistance is granted at _____ **% based on calculated household income of \$** _____ **and family size of** _____.

Assistance is denied due to:

- _____ **Income does not meet eligibility criteria**
- _____ **Missing information requested was not provided within 10 days**
- _____ **Application was not signed**

Notification to patient was mailed on _____
(date)

Signature of employee performing eligibility review: _____



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Income Verification

(Please complete the following for all adult members of the household as well as all children who are employed and complete a separate section for each employer if someone has more than one job)

Name: _____ Date _____ of _____ Birth: _____
Employer: _____ Date of _____ Hire: _____
Job Title: _____ Ave Hours _____ per _____ Week: _____
Pay Rate: \$ _____
_____ Please attach paystubs for 2 most recent months and enter information in table below:

Name: _____ Date _____ of _____ Birth: _____
Employer: _____ Date of _____ Hire: _____
Job Title: _____ Ave Hours per Week: _____
Pay Rate: \$ _____ per hour
Please attach paystubs for 2 most recent months and enter information in table below:

Name: _____ Date _____ of _____ Birth: _____
Employer: _____ Date of _____ Hire: _____
Job Title: _____ Ave Hours per Week: _____
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Job Title: _____ Ave Hours per Week: _____
Pay Rate: \$ _____ per hour
Please attach paystubs for 2 most recent months and enter information in table below:

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