



**HILLTOWN COMMUNITY HEALTH CENTERS, INC**  
*"This Institution is an Equal Opportunity Provider"*

## Sliding Fee Discount Application

Hilltown Community Health Centers, Inc. (HCHC) makes available a sliding fee discount program to ensure that no patient will be denied health care services provided by HCHC due to an inability to pay or based on race, color, religion, creed, sex, gender, gender identity or gender expression, age, marital status, national origin, mental or physical disability, political belief or affiliation, veteran status, sexual orientation, genetic information, and any other class of individuals protected from discrimination under state or federal law with respect to the provision of services.

Discounts are offered based on family size and annual household income. The Sliding Fee Discount Program will only be made available for medical, dental, optometry, and behavioral health clinic visits. Sliding Fee Discounts are not available for Optometry and/or Dental hardware, such as dentures and eyeglasses, and not for those services or equipment that are purchased from outside HCHC, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

To apply for the Sliding Fee Discount, please do the following:

1. Complete the application provided by Front Desk or Navigators.
2. Get copies of IDs, proof of income, and proof of residency for all people listed on the application.
  - a. *Proof of Income:* paystub, Social Security award letter, or workers comp
  - b. *Proof of Residency:* electric bill, property tax, rental agreement, or ID for head of household
3. Submit your application and all the documents requested. This can be done in person or by mail.
  - a. *In-Person:* Put all your documents in a sealed envelope. Write "For Karen Lampson" on the envelope and give it to the reception desk at any HCHC site.
  - b. *Mail:* Please mail your documents to:
 

Hilltown Community Health Center  
 c/o Karen Lampson  
 58 Old North Road  
 Worthington, MA 010

**If you have questions or need assistance completing this form please contact Karen Lampson, Health Access Supervisor, at 413-340-7814, or by email at [klampson@hchcweb.org](mailto:klampson@hchcweb.org).**

### Household/Family Information

Family is defined as: a group of two people or more (one of whom is the head of household) related by birth, marriage, or adoption and residing together and any person who is claimed as a dependent for Federal tax purposes; all such people (including related subfamily members) are considered as members of one family.

Patient Name:	
Relationship To Head Of Household:	
Household Mailing Address:	
Phone Number:	

**Defined Family Living at Household Address:**

<b>Name:</b>	<b>Date of Birth:</b>	<b>Relationship:</b>

**Annual Household Income:**

<b>Income Source:</b>	<b>Self:</b>	<b>Other Family Member(s):</b>	<b>TOTAL:</b>
Gross Wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security income, veterans' payments, survivors benefits, pension or retirement income.			
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.			
Total			

**NOTE: Please provide copies of all documents or self-declaration statements being used to verify income. A copy of your ID and proof of income are required to complete this application.**

I certify that the family size and income information shown above is correct.

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Official Use Only**

Patient Name:
Approved Discount:
Approved By:
Date Approved:
List of Documents used to verify Income, please attach copy: