SLIDING FEE SCALE PROGRAM

FREQUENTLY ASKED QUESTIONS

HOMETOWN Health Center
118 Moosehead Trail. Suite 5,
Newport, Maine 04953
1 -866-364-1366 OR 207-355-3440

Why should I apply?
You may qualify to pay a reduced visit fee when you come to a provider at HOMETOWN Health Center

How much will it cost?
There is no cost to apply for the program.
The visit fees range from $10 - $45 per visit depending on your household size and income. You may also qualify for a minimum fee of $45 for dental services or reduced charges for dental services.

What is covered?
This program covers healthcare services provided by HOMETOWN Health Center but does not cover visits to the hospital or other healthcare providers. You must apply at those places to participate in their programs. According to federal guidelines, HOMETOWN Health Center is required to update our sliding fee scale program annually based on changes made to the federal poverty income levels. This takes place on May 1st of each year. Therefore, the program you qualify for may change at that time.

How do I apply?
Complete the application. Be sure to provide information for all your household members. Bring in or send us proof of income for all your income sources. If you are not sure what that means, there is a list of what we need for each kind of income on the application checklist.

Does this mean that I have insurance and won't have to pay a fine on my taxes?
No. This program is not considered to be health insurance coverage for tax purposes.

Can I use this program if I have health insurance?
Yes. If you qualify based on your household number and income and your health insurance has high deductibles or co-pays, you can still use this program to reduce your health care expenses. This is a discount program for services at HOMETOWN Health Center.

What can the Health Care Marketplace can do for you?

- New health insurance coverage options are available through the Federal Marketplace.
- Low-cost and free plans are available and financial help is available based on how much money you make.
- No one can be denied coverage because they have a pre-existing condition.
- You may be eligible outside open enrollment if you have a life change such as marriage, relocation or the birth of a child, or if you lose your health insurance through job loss or losing MaineCare.

We can help, for free! call 1-866-364-1366 and ask for a Sliding Fee Application Assistance.

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INCOME GUIDELINES

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Poverty Level	100%	101% - 135%	136% - 150%	151% - 185%	*186% - 200%*
Qualifing Levels:	Cat 1	Cat 2	Cat 3	Cat 4	*Cat 5*
Medical & BH	Pays $10	Pays $15	Pays $25	Pays $35	Pays $45
Dental: Excluding prodedures	Pays $45	20%	40%	60%	80%
Total Household Size	Total Household Income	Total Household Income	Total Household Income	Total Household Income	Total Household Income
1	Under 12,140	12,141 to 16,389	16,390 to 18,210	18,211 to 22,459	22,460 to 24,280
2	Under 16,460	16,461 to 22,221	22,222 to 24,690	24,691 to 30,451	30,452 to 32,920
3	Under 20,780	20,781 to 28,053	28,054 to 31,170	31,171 to 38,443	38,444 to 41,560
4	Under 25,100	25,101 to 33,885	33,886 to 37,650	37,651 to 46,435	46,436 to 50,200
5	Under 29,420	29,421 to 39,717	39,718 to 44,130	44,131 to 54,427	54,428 to 58,840
6	Under 33,740	33,741 to 45,549	45,550 to 50,610	50,611 to 62,419	62,420 to 67,480
7	Under 38,060	38,061 to 51,381	51,382 to 57,090	57,091 to 70,411	70,412 to 76,120
8	Under 42,380	42,381 to 57,213	57,214 to 63,570	63,571 to 78,403	78,404 to 84,760
9	Under 46,700	46,701 to 63,045	63,046 to 70,050	70,051 to 86,395	86,396 to 93,400
10	Under 51,020	51,021 to 68,877	68,878 to 76,530	76,531 to 94,387	94,388 to 102,040
11	Under 55,340	55,341 to 74,709	74,710 to 83,010	83,011 to 102,379	102,380 to 110,680
12	Under 59,660	59,661 to 80,541	80,542 to 89,490	89,491 to 110,371	110,372 to 119,320

Sliding Fees must be paid at the time of the visit.

*Minimum payment for dental visit is $45.00

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APPLICATION

- A separate application is required for each member of the household who wants to participate in this program, including minor children.
- You must complete both sides of the application form
- If you need help call 1-866-364-1366 and ask for Sliding Fee Program assistance

Name:	Social Security #	Date of Birth:
Mailing Address:		
Telephone # / Message phone #	Do you have health insurance? If yes, please list insurer:	
Have you applied to MaineCare within the last year? We recommend that all applicants apply to MaineCare each year. Call us if you need assistance.	(Circle One) Have MaineCare Denied Maine Care Did not apply	

It is necessary for HOMETOWN Health Center to ask personal questions in order to determine if you are eligible for this program. This information will be kept on file in strict confidence. You must verify your income when you apply and once a year when your application is renewed. Copies of your yearly federal income tax return, payroll check stubs covering the past month, Social Security benefit statements or other income sources are required. We cannot use bank statements for this purpose. Your annual income and household size will be used to determine your visit fee.

I declare the above information is true and give HOMETOWN Health Center permission to investigate any information in this application.

I understand that:

- My information will be held in strict confidence.
- If this information is found to be false, I will lose my eligibility for the program and be liable to repay any benefit I have received.
- If my income or household size changes, I am required to notify the Billing Department as soon as possible,
- I have six weeks to return this application complete with proof of my annual income or this application will expire.
- I may reapply to the program at any time but reduced fees will apply only from the date of the new application.
- If I am found to be eligible for reduced fees but failed to make required payments, my account may be sent to a collection agency.

_____

Patient Signature Date:

_____

Parent/Legal Guardian Signature: Date:

For Office use only:	
Date Received: _____/_____/_____	
Date of Determination: ____/____/_____	
Level: 1 2 3 4 5	
	Application Expired
	Over Income

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APPLICATION CHECKLIST

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- Complete signed application for each applicant, listing all household members and income sources
- Proof of income for each income source
- If you have very low or no income, complete the "Zero Income Worksheet"
- Most recent federal tax return if you file taxes

HOUSEHOLD: Please list all names and date of births for all members of your household including yourself. If you file taxes your household is you, your spouse and any dependents you claimed on your taxes.

If you are claimed as a dependent by someone else, your household is you, the person who claims you and anyone else listed on their tax return.

If you do not file taxes and are not claimed as a dependent by anyone else, your household is you and your spouse and children if they live with you.

INCOME: You need to provide proof of income for each of the following sources of income for each member of your household to see if you qualify. Please note that we cannot accept bank statements as proof of income.

Employed: Pay stubs for the last four weeks OR federal tax return

Self-employment and Rental Income: you must provide a copy of your most recent federal tax return

Current Benefit Statement for:

Unemployment	Social Security	TANF
Worker's Compensation	Long or short term disability	Child support/Alimony
Retirement pension and or annuity		

First and Last Name	Relation to you	Date of birth	Gross income before taxes and deductions	Income Source With documents attached
	SELF		$_____per	
			$_____per	
			$_____per	
			$_____per	
			$_____per	

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Zero Income Worksheet

I, _____certify that I have not received any income since _____.

Place(s) of last employment: _____.

____ I am a full-time student over the age of 18.

Housing

I live in:

____ My own home/apartment Do you receive housing assistance? Yes No

____ Someone else's home/apartment Name of house/apartment owner: _____

____ Shelter/Transitional housing

____ Other: _____

Food

Do you receive Food Stamps?

____ Yes (If Yes, you must attach a copy from DHHS.)

____ No

Transportation

____ I have my own vehicle

____ A friend or relative provides me with transportation

____ I use public transportation

Communication Expenses

Do you have a cell phone? Yes No

If Yes, who pays for your cell phone? _____

All person(s) that have provided you with assistance in the past 3 months (monetary or non-monetary), must complete the following charts and sign below verify what assistance they have provided for you.

- **If someone has given you money to pay for expenses below, indicate how much they have paid and write their name in the appropriate box.**
- **If someone has provided you any of the below expenses for free, please indicate free and put their name in the appropriate box.**

EXAMPLE ONLY	**Month**	**May 2017**
	$ or Free?	Who Assisted?
Housing Expenses	Free	Mom
Utilities (water/sewer/electric)	included	
Heat	included	
Food Expenses	$189	Food stamps
Transportation Expenses	$20	Grandma
Communication Expenses	$40	Mom
Medical Expenses	none	
Other Expenses	none	

(Mom & Grandma would then sign form + attach food stamp letter)

Month # 1	**Month**	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Month # 2	**Month**	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Month #3	**Month**	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Printed Name and Signature of Person(s) who provided you with assistance:

_____ **Date:** _____

_____ **Date:** _____

*This form must be filled out completely; we will not.be able to process your application if you leave parts of it blank. If you need to tell us more about your specific situation, please feel free to attach a letter or statement to this worksheet. If you receive assistance from other agencies, (LiHeap, General Assistance etc.) please attach copies of any assistance provided to you.

I do hereby swear and attest that all the information above about me is true and correct.

Signature of Applicant _____ **Date:** _____