HOMETOWN Health Center

SLIDING FEE SCALE PROGRAM

FREQUENTLY ASKED QUESTIONS

118 Moosehead Trail, Suite 5
Newport, ME 04953
1-866-364-1366
hometownhealthcenter.org

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 Sliding Fee Scale program. Service fees are reduced on this program. The medical visit fees range from $10 - $45 per visit depending on your household size and income. You may also qualify for a minimum fee of $40 for dental hygiene (*cleanings*) service or reduced charges for other (non-hygiene related) dental services/procedures with the dentist.

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 March 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 adult 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.

Is this program considered to be health insurance?
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 355-3440 or 1-866-364-1366 and ask for Sliding Fee Application Assistance.

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INCOME GUIDELINES 2025

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

*Minimum payment for Dental Hygiene (cleanings) visits is $40

2025

Poverty Level	100%	101% - 135%	136% - 150%	151% - 185%	*186% - 200%*
Qualifing Levels:	Cat 1	Cat 2	Cat 3	Cat 4	*Cat 5*
Medical and Behavioral	Pays $10	Pays $15	Pays $25	Pays $35	Pays $45
Dental Hygiene	pays $40 & Labs	$45 or 20% & Labs	$45 or 40% & Labs	$45 or 60% & Labs	$45 or 80% & Labs
Total Household Size	Total Household Income	Total Household Income	Total Household Income	Total Household Income	Total Household Income
1	Under 15,650	15,651 to 21,128	21,129 to 23,475	23,476 to 28,953	28,954 to 31,300
2	Under 21,150	21,151 to 28,553	28,554 to 31,725	31,726 to 39,128	39,129 to 42,300
3	Under 26,650	26,651 to 35,978	35,979 to 39,975	39,976 to 49,303	49,304 to 53,300
4	Under 32,150	32,151 to 43,403	43,404 to 48,225	48,226 to 59,478	59,479 to 64,300
5	Under 37,650	37,651 to 50,828	50,829 to 56,475	56,476 to 69,653	69,654 to 75,300
6	Under 43,150	43,151 to 58,253	58,254 to 64,725	64,726 to 79,828	79,829 to 86,300
7	Under 48,650	48,651 to 65,678	65,679 to 72,975	72,976 to 90,003	90,004 to 97,300
8	Under 54,150	54,151 to 73,103	73,104 to 81,225	81,226 to 100,178	100,179 to 108,300
9	Under 59,650	59,651 to 80,528	80,529 to 89,475	89,476 to 110,353	110,354 to 119,300
10	Under 65,150	65,151 to 87,953	87,954 to 97,725	97,726 to 120,528	120,529 to 130,300
11	Under 70,650	70,651 to 95,378	95,379 to 105,975	105,976 to 130,703	130,704 to 141,300
12	Under 76,150	76,151 to 102,803	102,804 to 114,225	114,226 to 140,878	140,879 to 152,300

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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 355-3440 or 1-866-364-1366 and ask for Sliding Fee Program assistance

Name:		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:

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APPLICATION CHECKLIST

- Complete signed application for each applicant, listing all household members and income sources
- Proof of income for each income source for each adult
- **If you have very low or no income, you must complete the "Zero Income Worksheet" for each adult to be considered for the program.**
- 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.

If you have very low or no income, you must complete the Zero Income Worksheet (pages 5 & 6)

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

Application for (*person with NO income*): _____

Date of Birth: _____

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 *Person with No Income*: _____ **Date:** _____