Eastport Health Care, Inc.
Sliding Fee Discount 2018
Application for Sliding Fee Discount

Office Use Only:

SF Level: _____

Income: _____

Expiration: _____

Info verified & primary approval given by:

_____

Date: _____

Final review & approval given by

_____

Date: _____

Date of Request _____ New _____ Renew _____

Type of Service (medical, dental, counseling) _____
I hereby request that Eastport Health Care, Inc. makes a written determination of my eligibility for the sliding fee discount.

Name _____
First MI Last

Address _____ City _____

Zip _____ Telephone _____

Social Security Number _____-_____-_____ Date of Birth _____

Employer & Address _____

Current insurance (Mainecare, Medicare, private insurance)_____

Income: **List all income for Household** (include copies) Total for Month or Total for Year

Wages _____
Farm or Self Employment _____
Public Assistance _____
Social Security _____
Unemployment Compensation _____
Workman's Compensation _____
Fishing _____
Tipping, Wreathing _____
Child Support, Alimony _____
Military Family Allotments _____
Pensions _____
Dividends, interest or rental income _____

Number of people living in your home (including yourself): _____

Name	Relationship	Date of Birth	SS#	Occupation

I affirm that the above is true and correct to the best of my knowledge. I agree to immediately notify EHC of any change in my income.

_____

Signature of person making request **Date**

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Use this space for any additional members of the family:

Name	Relationship	Date of Birth	SS#	Occupation

You will need to provide a copy of at least one of these examples of income information:

Wages (pay stubs for the month, W2 tax forms)
1040 Tax form (most current)
Self-Employment (business, farming, fishing) (bank statements or checks deposited)
Social Security (bank statement of direct deposit or tax form SSA-1099, or current year benefit letter – you can request a letter by calling 1-877-405-1448)
Tipping, Wreathing (copies of checks or receipts from buyers)
Alimony (copy of check for the month)
Pensions (benefits statement)
Dividends, interest or rental income (copy of checks or tax statements)
Unemployment (unemployment letter or weekly report showing current benefits call 1-800-593-7660)
Worker's Compensation (tax form 1099-G) or benefit letter
Mainecare (eligibility letter)
Letter signed by family or friends explaining the support they are giving you
Bank statements or request a letter from your bank to show weekly or monthly deposits

1. Fill in the front side of application (use the above section if needed for additional family members).
    a. Put today's date at the top
    b. Specify the type(s) of services you are requesting – medical, dental, counseling
    c. List current insurance coverage if any
    d. List all income for everyone in your household
    e. Please answer **ALL** questions
    f. Your dated signature must be at the bottom of the application

2. **You will need to include proof of all household income for at least one month**, with your application. We cannot process your application until we have this proof.
3. Those you list as household members are considered for coverage as well. If you are approved, they may receive the same services as you. **Please state if they are not requesting services.**
4. Mail your application and income proof to EHC or drop it off at the front desk within 30 days of your visit.

Thank you for applying for the Sliding Fee Discount. If you have any questions or concerns, please do not hesitate to call Deb Shields, 207-**853-0189 or email dshields@eastporthealth.org. Mail applications to EHC, P.O. Box H / 30 Boynton St., Eastport, ME 04631**

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EHC offers a sliding fee scale to all its patients. The Sliding fee scale covers all approved scope of project services provided by EHC.

The sliding fee scale is based on income limits and is available to patients with or without insurance. Medicare patients are also eligible - the sliding fee scale may cover a portion of the 20% coinsurance. We will assist you with a Marketplace or Mainecare application if applicable as part of this process. Patients are required to apply for Sliding Fee Discount (SFD) annually.

Patients who meet federal guidelines and who submit all the required paperwork with the application, may receive a SFD for services rendered. Patients who receive the Sliding Fee are expected to pay their portion or co-pay at the time of service. Patients who qualify for Category A-1 may qualify to have their copay waived if there is hardship.

EHC Sliding Fee Discount for Dental lab services (i.e. dentures, bridges, crowns, and DME supplies etc.):

- **For all dental procedures that require lab services: 50% must be paid prior to the first visit and the remainder before delivery.**
- **Dental implants and Invisalign® treatments are not covered under the sliding fee program**
- **Annual benefit limits (i.e.: 1 crown per year) will mirror Delta Dental Insurance**
- **Medical lab services by Affiliated Lab only will be discounted at the same rate as EHC Sliding Fee Discount.**

If your gross income falls within the ranges listed below, you may be eligible for a sliding fee discount. Any of our staff can give you an application and answer basic questions or contact Deb Shields, Benefits Coordinator, at 853-0189 for further assistance. All information is kept confidential.

Poverty Level	100% or less	101% to 125%	126% to 150%	151% to 200%	Over 201%
	Nominal Charge	Partial Charge	Partial Charge	Partial Charge	Ineligible
	Category A	**Category B**	**Category C**	**Category D**	
Family Size	$15.00 copay	$30.00 copay	$40.00 copay	$50.00 copay	Full
1	0-$12,140	$12,141-$15,175	$15,176-$18,210	$18,211-$24,280	$24,281 +
2	0-$16,460	$16,461-$20,575	$20,576-$24,690	$24,691-$32,920	$32,921 +
3	0-$20,780	$20,781-$25,975	$25,976-$31,170	$31,171-$41,560	$41,561 +
4	0-$25,100	$25,101-$31,375	$31,376-$37,650	$37,651-$50,200	$50,201 +
5	0-$29,420	$29,421-$36,775	$36,776-$44,130	$44,131-$58,840	$58,841 +
6	0-$33,740	$33,741-$42,175	$42,176-$50,610	$50,611-$67,480	$67,481 +
7	0-$38,060	$38,061-$47,575	$47,576-$57,090	$57,091-$76,120	$76,121 +
8	0-$42,380	$42,381-$52,975	$52,976-$63,570	$63,571-$84,760	$84,761 +
for each	additional	person add $4,320.00			

Based on 2018 DHHS Poverty Guidelines published source: Federal Register, January 18, 2018 revised 1/18/18

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Type of Service and corresponding discounts

Service	Category A	Category B	Category C	Category D	Ineligible (Over 201%)
Medical Care	$15	$30	$40	$50	Full
BH Counseling	$15	$30	$40	$50	Full
Preventative Dental	$15	30%	55%	80%	Full
Filling/extractions	$15	30%	55%	80%	Full
Crowns/Flexible partial denture	$400	$550	$700	$850	Full
Partials, Crowns (metal)	$450	$650	$850	$1,000	Full
Full Dentures (per arch)	$475	$700	$900	$1,050	Full