Eastport Health Care, Inc.
Sliding Fee Discount 2026
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 (*Optional)* _____-_____-_____ Date of Birth _____

Employer & Address _____

Current insurance (Mainecare, Medicare, private insurance)_____

Income: **List all income for Household** (include copies). If you filed a tax return last year or this year, it must be provided.

	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	Relation	DOB	SSN (*Optional)*	Occupation	Requesting Services
					Y N
					Y N
					Y N
					Y N

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	Relation	DOB	SSN	Occupation	Requesting Services
					Y N
					Y N
					Y N
					Y N

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 Ashley Scott at **(207) 853-6001 EXT 2614 or email** EHCpatientservices@protonmail.com Mail **applications to EHC, 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 help guide you to the correct agency for help 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 Quest Lab for patients who are at or below 200% of the federal poverty guideline will be eligible for 100% 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 Ashley Scott at (207) 853-6001 EXT 2614 for further assistance. All information is kept confidential.

Poverty Level	100% or less	101% to 125%	126% to 150%	151% to 200%	Over 200%
	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-$15,960	$15,961-$19,950	$19,951-$23,940	$23,941-$31,920	$31,921+
2	0-$21,640	$21,641-$27,050	$27,051-$32,460	$32,461-$43,280	$43,281+
3	0-$27,320	$27,321-$34,150	$34,151-$40,980	$40,981-$54,640	$54,641 +
4	0-$33,000	$33,001-$41,250	$41,251-$49,500	$49,501-$66,000	$66,001 +
5	0-$38,680	$38,681-$48,350	$48,351-$58,020	$58,021-$77,360	$77,361 +
6	0-$44,360	$44,361-$55,450	$55,451-$66,540	$66,541-$88,720	$88,721 +
7	0-$50,040	$50,041-$62,550	$62,551-$75,060	$75,061-$100,080	$100,081 +
8	0-$55,720	$55,721-$69,650	$69,651-$83,580	$83,581-$111,440	$111,441 +
for each	additional	person add $5,680			

Based on 2026 DHHS Poverty Guidelines published source: Federal Register, January 13, 2026 revised 1/15/2026

approved by the Board of Directors January 27, 2026

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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

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