HealthWays/Regional Medical Center at Lubec (RMCL)
Sliding Fee Discount Program

What is the Sliding Fee Discount Program? RMCL offers a Sliding Fee Discount (SFD) program to provide accessible and affordable healthcare to patients regardless of their ability to pay. When you apply to participate in this program, we will review your application and assess your level of income to determine which income category best applies to the amount you pay for your services.

All of your information is reviewed internally by our Outreach and Enrollment Specialist. RMCL does not report your personal information to any outside entity without your written consent.

What services are covered in the SFD program? Sliding fee rates are determined by your approved income category: A, B, C, or D. The rates you pay for services you receive per provider apply to the following services:

- **Medical care**: All examinations and other medical services provided internally by RMCL medical staff.
- **Counseling**: All services provided by RMCL Behavioral Health and Substance Use Disorder Counselors.
- **Dental**: All preventive exams, cleanings, hygiene, x-rays, emergency dental services, restorative fillings, extractions, deep root scaling, pain relief, root canals, occlusal guards, reline or rebase of partial and complete dentures, *full/partial dentures, and crowns.

You receive the same quality care and services whether you receive the discounted rates or not. Your provider does not consider your sliding fee category when providing care to you.

What services are not covered in the SFD program? Excluded services include, but are not limited to specimens sent to outside labs, diabetic shoes, and orthotics.

What are the categories? Based on your approved income category, you will only pay the following amounts per provider encounter:

Service	Category A	Category B	Category C	Category D
Medical, Counseling, and Preventive Dental Services	$15.00	$25.00	$35.00	$45.00
Restorative Dental Services / Other Dental	$15.00	$45.00	$55.00	$75.00
Root Canals	$180.00	$360.00	$540.00	$720.00
Temporary Dental Devices and Maintenance	$200.00	$300.00	$400.00	$500.00
Crowns, Fixed Prosthodontics, Bridges, and Partial Dentures	$400.00	$600.00	$800.00	$1,000.00
Full Dentures	$800.00	$1,200.00	$1,600.00	$2,000.00

What category would apply to my income based on my household size?

Estimated yearly income by household size (circle household size and income category):					
Household Size	**Category A**	**Category B**	**Category C**	**Category D**	**Category E**
1 Person →	$0.00 - $14,580	$14,581 - $18,225	$18,226 - $21,870	$21,871 – $29,160	$29,161 or more
2 People →	$0.00 - $19,720	$19,721 - $24,650	$24,651 - $29,580	$29,581 - $39,440	$39,441 or more
3 People →	$0.00 - $24,860	$24,861 - $31,075	$31,076 - $37,290	$37,291 - $49,720	$49,721 or more
4 People →	$0.00 - $30,000	$30,001 - $37,500	$37,501 - $45,000	$45,001 – $60,000	$60,001 or more
5 People →	$0.00 - $35,140	$35,141 - $43,925	$43,926 - $52,710	$52,711 - $70,280	$70,281 or more
6 People →	$0.00 - $40,280	$40,281 - $50,350	$50,351 - $60,420	$60,421 - $80,560	$80,561 or more
7 People →	$0.00 - $45,420	$45,421 - $56,775	$56,776 - $68,130	$68,131 - $90,840	$90,841 or more
8 People →	$0.00 - $50,560	$50,561 - $63,200	$63,201 - $75,840	$75,841 - $101,120	$101,121 or more
Add per additional member	$5,410	$6,763	$8,115	$10,820	N/A

February 1, 2023-Approved by the RMCL Board of Directors: 2023.01.31 Based on 2023 DHHS Poverty Guidelines Published Resource: Federal Register, 01/19/2023

We encourage all patients to apply for this beneficial program. You may apply if you are employed, self-employed, unemployed, retired, etc., even if you already have insurance coverage. Start your enrollment today by completing the application on the third page of this packet.

Proof of Income

We cannot process your application until we have appropriate proof of income.

Conditional Approval: This application can be completed by you at any time during the year. You may apply for the SFD program even if you have insurance coverage. If your expected income appears to show you are eligible for the SFD program at the time you complete the form in our office, we will grant you conditional approval for up to 30 days; however, if you do not submit proof of income within two (2) weeks of the application date, we will assume that you are declining participation in the SFD program and will send you a denial letter.

This application and proof of income must be returned to RMCL within two (2) weeks of your visit. Your application will be returned to you for correction if any required information is missing. **Eligibility will be delayed until all information is corrected and re-submitted for approval.**

All applicants are screened by our Outreach Coordinator for eligibility for other services such as MaineCare. We do not submit any official screening documents to MaineCare. If you are eligible, we can assist you applying for these additional services.

What Proof of Income Documents do I need to send with the form?

One or more of the following for each eligible/countable household member is accepted as valid proof of income:

- W-2 or tax return for the most recent year (with applicable backup schedules)
- Paycheck stubs (or proof of income from an employer) for the four (4) most recent weeks from the date of this application
- Letter from the employer
- Statements from social service agencies such as unemployment, Social Security, TANF, etc.
- Proof of Deductions to total income, such as (HSA/FSA) deductions, and pre-tax health/dental insurance premiums paid, alimony paid, student interest, tuition fees, and self-employment tax.
- **Self-employed**: If you are self-employed, please submit the following:
    - a detail of the most recent three (3) months of income and expenses for your business; **or**,
    - a copy of your completed and signed tax return for the most recent year including Schedule C.
- **No income:** If you are unable to provide proof of income, you may submit the following:
    - a signed statement from the person(s) who provides you with food and shelter; or,
    - sign a statement of income stating why you are unable to provide verification.

You may receive a letter from RMCL requesting additional information, if needed.

How do I return the form?

You may complete the attached application in our office or at home. Completed applications and proof of income documents must be mailed or delivered to:

The Regional Medical Center at Lubec
Attention: Angela Dubey
43 South Lubec Rd.
Lubec, Maine 04652

What happens next?

You will receive a letter within two (2) weeks after we received your completed application and proof of income documents to let you know whether you are approved and the fee category you qualify for, or to provide a reason for denial. Everyone you list as an eligible/countable family member is considered for coverage. If you are approved, they will receive the same level of discount as you receive for each appointment during the year. Sliding fee approval expires and must be renewed after one full year. We will send a reminder to you each year in advance of the expiration date so that you will not experience a lapse in discount coverage.

Thank you for applying for the Sliding Fee Discount Program. If you have any questions or concerns, please do not hesitate to call Angela Dubey, Outreach and Enrollment Specialist at 207-733-5541.

Regional Medical Center at Lubec (RMCL)
Sliding Fee Discount Program (SFD) Application

Version 02/01/2023

Instructions: Read and complete sections 1-13 **and** include the **Proof of Income documents listed on the prior page.**

RMCL Office Use Only
SF Level: A B C D E
Income: $_____
Coverage Begins: ___/___/___
Coverage Expires: ___/___/___
Supervisor: ____ ___/___/___

1. Name of Applicant (Please Print) _____

2. Date you are completing this application: ___/___/____

3. Type of request (circle one): New Request Annual Renewal

4. Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

5. Current home phone #: (____)_____-_____ **Current cell phone #:** (_____)_____-_____

6. E-mail Address: _____

Complete the information below for yourself and all eligible/countable family members:

"Eligible/countable family members" include spouses/domestic partners; biological/adopted/unborn children under age 21 living in the household or away at school and claimed as tax dependents; and unmarried fathers of unborn children. Do not include roommates, friends, and others who are not self-declared partners living in the home.

7. The number of eligible/countable family members in my household is: _____

8. Enter the names of each household member in the table below:

Last Name	*First Name*	*Relationship to You*	*Date of Birth*

List ALL income for you and each person listed above:

"Income" includes all income (taxable & non-taxable) and amounts are before and not after tax. Income consists of wages, tips, profit/loss from self-employment, unemployment compensation, Workers' Compensation, all Social Security benefits, all veterans' benefits, pension, retirement, interest, dividends, rental income, royalties, alimony received, trusts, Temporary Aid for Needy Families (TANF), and child support.

9. The Income Amounts I am Entering in the Table Below Are (Circle one): Weekly Monthly Annually

10. Source of Income	**Your Income**	**Family Member**	**Family Member**
Wages, salaries, tips, etc.			
Business and/or rental income			
Social Security and veteran's benefits			
IRAs, pensions, annuities, and trusts			
Alimony and child support received			
Interest, royalties, and dividends			
Workers' comp., unemployment or TANF			

List ALL deductions for you and each person listed above:

"Deductions" to total income include any Health Savings Account/Flexible Spending Account (HSA/FSA) deductions, and pre-tax health/dental insurance premiums paid, alimony paid, student interest, tuition fees, and self-employment tax.

11. Source of Deduction	**Your Deductions**	**Family Member**	**Family Member**

12. If you would like assistance completing applications for MaineCare coverage, please check this box ☐

13. *I hereby request that the RMCL make a written determination of my eligibility for the Sliding Fee Discount. I affirm that all the above information is complete and true to the best of my knowledge. I understand that I will be held liable for charges if the information supplied is false. I agree to immediately notify RMCL of any changes to my income or family size.*

Sign Here: _____ **Date:** ____/___/____