HealthWays

The Regional Medical Center at Lubec, Inc.

Sliding Fee Discount Program Instructions

WHAT IS THE SLIDING FEE DISCOUNT PROGRAM?

The Sliding Fee Discount Program (SFDP) enables us to discount the medical, dental, and behavioral health services we provide as a Federally Qualified Health Center (FQHC). We encourage you to apply for the Sliding Fee Discount Program as many patients in our geographic area may be eligible to receive services at a discounted rate.

HOW IS YOUR SLIDING FEE DISCOUNT DETERMINED?

The Sliding Fee discount is determined based on your income level and members in your household as compared to the annual Federal Poverty Guidelines. The discount may apply to all qualified household members and may last up to one year with the appropriate documentation.

HOW CAN I QUALIFY FOR A SLIDING FEE DISCOUNT?

All individuals are eligible to apply for the SFDP. To qualify, your household income must be below 200% of the current Federal Poverty Guidelines. We request documentation of your income level and the number of eligible members in your household. You may qualify for the discount if you have insurance!

WHAT TYPE OF DOCUMENTATION DO I NEED TO PROVIDE?

Copies of wage statements, unemployment/pay stubs, tax returns, W-2s, social security benefit statements are all examples of acceptable forms of verification. If you do not currently have an income, a letter from a family member who is assisting you with income may be written on your behalf.

WHAT HAPPENS IF I DO NOT PROVIDE THE DOCUMENTATION?

Failure to provide income verification within 2 weeks (14 calendar days) of the date of your application will result in a denial of the discount program. We can update your application date once you provide the necessary documentation.

The amount you pay for services depends on which income category you qualify for below:

Service	Category A	Category B	Category C	Category D	E (Ineligible)
Medical Care	$15	$25	$35	$45	Full
Counseling Services	$15	$25	$35	$45	Full
Preventive Dental	$15	$25	$35	$45	Full
Restorative/other Dental	$15	$45	$55	$75	Full
Root Canals	$180	$360	$540	$720	Full
Dental Temp Devices & Maintenance	$200	$300	$400	$500	Full
Partial Dentures & Crowns	$400	$600	$800	$1,000	Full
Dental Post or other labs	$200	$300	$400	$500	Full
Dentures (full set)	$800	$1,200	$1,600	$2,000	Full
Medical Temp Devices (IUDs)	$400	$600	$800	$1,000	Full
Uninsured Vaccine/Drug (Pneumococcal, etc.)	$400	$600	$800	$1,000	Full

Turn the page to complete the application

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Complete this application and return it to one of our offices. Remember to **provide household income verification within 2 weeks of the application date. Examples of income verification may include copies of wage statements, unemployment/pay stubs, tax returns, W-2s, social security benefit statements are all examples of acceptable forms of verification. If you do not currently have an income, a signed letter from a family member who is assisting you with income may be written on your behalf**.

Patient Information

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____-_____ Birthdate: _____ Social Security #_____

Marital Status: _____ Alternative Contact Number: _____

Members of Household (Please include yourself)

	NAME	BIRTHDATE	RELATIONSHIP
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Income Information

Monthly Income $_____ Annual Income $_____

Are you currently employed? ☐ YES ☐ NO

Source(s) of household income? _____

Do you have other health insurance, including Medical, Dental, Medicare, Medicaid, etc.? ☐ YES ☐ NO

Name of Insurance: _____ Policy ID: _____

By signing below, I certify that the information provided on this form is true and correct to the best of my knowledge. If the information provided on this form is false or information was deliberately withheld to become eligible, I acknowledge that I will be responsible for the total charges incurred.

Remember to provide your household income documents within two weeks of this application!

_____ _____

Signature *Date*

Office Use Only: Date application received: _____ Application Eligibility Date (POI Receipt date): _____

- Approved for Slide Level: _____ Signature of Patient Outreach Coordinator: _____ Date: _____
- Denied (Reason): _____ Approved by: _____ Date: