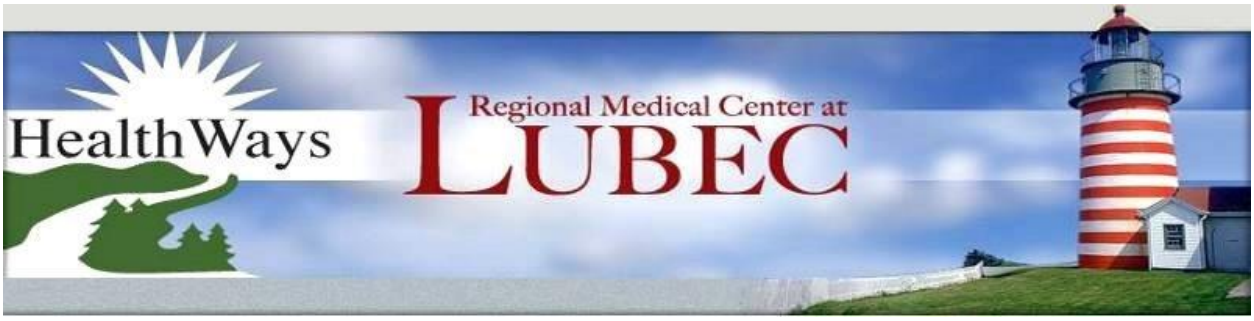

Sliding Fee Discount Program Instructions

WHAT IS A SLIDING FEE DISCOUNT?

Healthway's/Regional Medical Center at Lubec's sliding fee discount program enables us to discount qualifying services provided by HW/RMCL. Most patients may be eligible and are encouraged to apply for the sliding fee discount program.

HOW IS YOUR SLIDING FEE DISCOUNT DETERMINED?

Sliding Fee discount is determined based on your income level and members in your household. The Sliding Fee discount amount is based on annual federal poverty guidelines. A percentage of the visit charges will be discounted. This Sliding Fee discount may apply to all 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 Sliding Fee discount. To qualify, your household income must be below 200% of the federal poverty guidelines. HW/RMCL requests documentation of your income and the numbers of members in your household.

WHAT TYPE OF DOCUMENTATION DO I NEED TO PROVIDE?

Verification of income. Copies of wage statements, unemployment/pay stubs, tax returns, W-2's, social security benefit statements are all 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 right a letter on your behalf.

WHAT HAPPENS IF I DO NOT PROVIDE THE DOCUMENTATION?

Failure to provide income verification in some form will result in a denial of the discount program.

SLIDING FEE DISCOUNT PROGRAM APPLICATION

To determine your eligibility, please complete this application and provide household income verification. Verification documents include tax returns, wage statements, retirement statements, social security statements, and/or bank statements.

This application applies to the Sliding Fee Discount Program for medical, dental, and behavioral health services.

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.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

INCOME AND EMPLOYMENT

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.

_____ _____

Signature ***Date***

FOR OFFICE USE ONLY

VERIFICATION GIVEN BY PATIENT

☐ Pay Stubs
☐ Unemployment Verification Statement
☐ W-2's
☐ 1099's
☐ Bank Statements
☐ Social Security Benefit Statements
☐ Letter from family member
☐ Letter from employer

Qualifying Sliding Fee Discount Category: _____

Service	Category A	Category B	Category C	Category D
Medical, Counseling, Preventative Dental	$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

Application is: Approved ☐ Denied ☐

Reason for Denial:

_____
_____
_____
_____

_____ _____
Authorized By Date