HOMETOWN Health Center

SLIDING FEE SCALE PROGRAM

FREQUENTLY ASKED QUESTIONS

118 Moosehead Trail, Suite 5
Newport, ME 04953
1-866-364-1366
hometownhealthcenter.org

Why should I apply?
You may qualify to pay a reduced visit fee when you come to a provider at Hometown Health Center

How much will it cost?
There is no cost to apply for the Sliding Fee Scale program. Service fees are reduced on this program. The medical visit fees range from $10 - $45 per visit depending on your household size and income. You may also qualify for a minimum fee of $40 for dental hygiene (*cleanings*) service or reduced charges for other (non-hygiene related) dental services/procedures with the dentist.

What is covered?
This program covers healthcare services provided by Hometown Health Center but does not cover visits to the hospital or other healthcare providers. You must apply at those places to participate in their programs. According to federal guidelines, Hometown Health Center is required to update our sliding fee scale program annually - based on changes made to the federal poverty income levels. This takes place on March 1st of each year. Therefore, the program you qualify for may change at that time.

How do I apply?
Complete the application. Be sure to provide information for all your adult household members. Bring in or send us proof of income for all your income sources. If you are not sure what that means, there is a list of what we need for each kind of income on the application checklist.

Is this program considered to be health insurance?
No. This program is not considered to be health insurance coverage for tax purposes.

Can I use this program if I have health insurance?
Yes. If you qualify based on your household number and income and your health insurance has high deductibles or co-pays, you can still use this program to reduce your health care expenses. This is a discount program for services at Hometown Health Center.

What can the Health Care Marketplace can do for you?

- New health insurance coverage options are available through the Federal Marketplace.
- Low-cost and free plans are available and financial help is available based on how much money you make.
- No one can be denied coverage because they have a pre-existing condition.
- You may be eligible outside open enrollment if you have a life change such as marriage, relocation or the birth of a child, or if you lose your health insurance through job loss or losing MaineCare.

We can help, for free!
Call 355-3440 or 1-866-364-1366 and ask for Sliding Fee Application Assistance.

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INCOME GUIDELINES 2024

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Sliding Fees must be paid at the time of the visit.

*Minimum payment for Dental Hygiene (cleanings) visits is $40

2024

Poverty Level	100%	101% - 135%	136% - 150%	151% - 185%	*186% - 200%*
Qualifing Levels:	Cat 1	Cat 2	Cat 3	Cat 4	*Cat 5*
Medical & Behavioral	Pays $10	Pays $15	Pays $25	Pays $35	Pays $45
Dental Hygiene	pays $40 & Labs	$45 or 20% & Labs	$45 or 40% & Labs	$45 or 60% & Labs	$45 or 80% & Labs
Total Household Size	Total Household Income	Total Household Income	Total Household Income	Total Household Income	Total Household Income
1	Under 15,060	15,061 to 20,331	20,332 to 22,590	22,591 to 27,861	27,862 to 30,120
2	Under 20,440	20,441 to 27,594	27,595 to 30,660	30,661 to 37,814	37,815 to 40,880
3	Under 25,820	25,821 to 34,857	34,858 to 38,730	38,731 to 47,767	47,768 to 51,640
4	Under 31,200	31,201 to 42,120	42,121 to 46,800	46,801 to 57,720	57,721 to 62,400
5	Under 36,580	36,581 to 49,383	49,384 to 54,870	54,871 to 67,673	67,674 to 73,160
6	Under 41,960	41,961 to 56,646	56,647 to 62,940	62,941 to 77,626	77,627 to 83,920
7	Under 47,340	47,341 to 63,909	63,910 to 71,010	71,011 to 87,579	87,580 to 94,680
8	Under 52,720	52,721 to 71,172	71,173 to 79,080	79,081 to 97,532	97,533 to 105,440
9	Under 58,100	58,101 to 78,435	78,436 to 87,150	87,151 to 107,485	107,486 to 116,200
10	Under 63,480	63,481 to 85,698	85,699 to 95,220	95,221 to 117,438	117,439 to 126,960
11	Under 68,860	68,861 to 92,961	92,962 to 103,290	103,291 to 127,391	127,392 to 137,720
12	Under 74,240	74,241 to 100,224	100,225 to 111,360	111,361 to 137,344	137,345 to 148,480

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APPLICATION

- A separate application is required for each member of the household who wants to participate in this program, including minor children.
- You must complete both sides of the application form
- If you need help call 355-3440 or 1-866-364-1366 and ask for Sliding Fee Program assistance

Name:	Social Security #	Date of Birth:
Mailing Address:		
Telephone # / Message phone #	Do you have health insurance? If yes, please list insurer:	
Have you applied to MaineCare within the last year? We recommend that all applicants apply to MaineCare each year. Call us if you need assistance.	(Circle One) Have MaineCare Denied Maine Care Did not apply	

It is necessary for HOMETOWN Health Center to ask personal questions in order to determine if you are eligible for this program. This information will be kept on file in strict confidence. You must verify your income when you apply and once a year when your application is renewed. Copies of your yearly federal income tax return, payroll check stubs covering the past month, Social Security benefit statements or other income sources are required. We cannot use bank statements for this purpose. Your annual income and household size will be used to determine your visit fee.
I declare the above information is true and give HOMETOWN Health Center permission to investigate any information in this application.

I understand that:

- My information will be held in strict confidence.
- If this information is found to be false, I will lose my eligibility for the program and be liable to repay any benefit I have received.
- If my income or household size changes, I am required to notify the Billing Department as soon as possible,
- I have six weeks to return this application complete with proof of my annual income or this application will expire.
- I may reapply to the program at any time, but reduced fees will apply only from the date of the new application.
- If I am found to be eligible for reduced fees but failed to make required payments, my account may be sent to a collection agency.

_____

Patient Signature Date:

_____

Parent/Legal Guardian Signature: Date:

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APPLICATION CHECKLIST

- Complete signed application for each applicant, listing all household members and income sources
- Proof of income for each income source for each adult
- **If you have very low or no income, you must complete the "Zero Income Worksheet" for each adult to be considered for the program.**
- Most recent federal tax return if you file taxes

HOUSEHOLD: Please list all names and date of births for all members of your household **including yourself**. If you file taxes your household is you, your spouse and any dependents you claimed on your taxes.

If you are claimed as a dependent by someone else, your household is you, the person who claims you and anyone else listed on their tax return.

If you do not file taxes and are not claimed as a dependent by anyone else, your household is you and your spouse and children if they live with you.

INCOME: You need to provide proof of income for each of the following sources of income for each member of your household to see if you qualify. Please note that we cannot accept bank statements as proof of income.

If you have very low or no income, you must complete the Zero Income Worksheet (pages 5 & 6)

Employed: Pay stubs for the last four weeks OR federal tax return

Self-employment and Rental Income: you must provide a copy of your most recent federal tax return

Current Benefit Statement for:

Unemployment	Social Security	TANF
Worker's Compensation	Long or short term disability	Child support/Alimony
Retirement pension and or annuity		

First and Last Name	Relation to you	Date of birth	Gross income before taxes and deductions	Income Source With documents attached
	SELF		$_____per	
			$_____per	
			$_____per	
			$_____per	
			$_____per	

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Zero Income Worksheet

Application for (*person with NO income*): _____

Date of Birth: _____

I,_____certify that I have not received any income since_____.

Place(s) of last employment:_____.

_____I am a full-time student over the age of 18.

Housing

I live in:

_____My own home/apartment Do you receive housing assistance? Yes No

_____Someone else's home/apartment Name of house/apartment owner: _____

_____Shelter/Transitional housing

_____Other: _____

Food

Do you receive Food Stamps?

_____Yes (If Yes, you must attach a copy from DHHS.)

_____No

Transportation

_____I have my own vehicle

_____A friend or relative provides me with transportation

_____I use public transportation

Communication Expenses

Do you have a cell phone? Yes No

If Yes, who pays for your cell phone? _____

All person(s) that have provided you with assistance in the past 3 months (monetary or non-monetary), must complete the following charts and sign below verify what assistance they have provided for you.

- **If someone has given you money to pay for expenses below, indicate how much they have paid and write their name in the appropriate box.**
- **If someone has provided you any of the below expenses for free, please indicate free and put their name in the appropriate box.**

EXAMPLE ONLY	**Month**	**May 2017**
	$ or Free?	Who Assisted?
Housing Expenses	Free	Mom
Utilities (water/sewer/electric)	included	
Heat	included	
Food Expenses	$189	Food stamps
Transportation Expenses	$20	Grandma
Communication Expenses	$40	Mom
Medical Expenses	none	
Other Expenses	none	

(Mom & Grandma would then sign form + attach food stamp letter)

Month # 1	**Month**	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Month # 2	**Month**	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Month #3	**Month**	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Printed Name and Signature of Person(s) who provided you with assistance:

_____ **Date:** _____

_____ **Date:** _____

*This form must be filled out completely; we will not.be able to process your application if you leave parts of it blank. If you need to tell us more about your specific situation, please feel free to attach a letter or statement to this worksheet. If you receive assistance from other agencies, (LiHeap, General Assistance etc.) please attach copies of any assistance provided to you.

I do hereby swear and attest that all the information above about me is true and correct.

Signature of *Person with No Income*: _____ **Date:** _____