Katahdin Valley Health Center

2017 Sliding Fee Application

You may be eligible for a sliding fee discount for medical, dental, pharmacy, and optometry services– even if you have insurance.

529 South Patten Road
Patten , ME 04765

Phone: 1-866-366-5842
Fax: 207-528-2880

Our sliding fee discount, which is based on ***household income,*** is available to all KVHC patients that qualify.

Please take the time to complete and sign the sliding fee application. Your Sliding Fee Application must be completed within 30 days. If supporting documentation is not received within that time frame a new application will need to be completed. Please be aware we require **two** forms of financial information for each adult in the household.

If **you filed** a 2016 Federal Income Tax return **we are required to have a signed copy on file.**

- Signed 2016 Federal Income Tax Return with **W-2 forms attached**. (Both signatures are required if filed jointly)
- Please submit any pertinent schedules, such as schedule C, D, E, or F.
- If you do not have your 2016 taxes, you can request a copy of the return transcript by calling the IRS at 1-800-829-1040 or online at: http://www.irs.gov/Individuals/Get-Transcript

Please provide a second form of income documentation for each adult in the household.

If you are **not required to file** income taxes, please submit two of the following documents as proof of income:

- **Three recent months** of consecutive bank statements showing direct deposit of income.
- Annual Social Security Benefit Statement *(If you do not have a benefit statement, you can request a copy by calling Social Security at 1-800-772-1213.)*
- Employment paystubs for the last **four** weeks.
- Unemployment Statement
- TANF Statement

If you have any questions regarding the sliding fee application process, please feel free to contact our Eligibility Department at 1-866-366-5842 extension 325.

Katahdin Valley Health Center provides community accessible, quality healthcare with compassion and dignity.

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2017 Sliding Fee Application

You will be required to provide proof of income in order to qualify for the sliding fee.

Please check all that apply. Medical Patient ☐ Dental Patient ☐ Optometry Patient ☐ KVHC Pharmacy ☐

Name:_____ Date Of Birth:_____

Mailing Address: _____City_____ State _____Zip_____

Phone:_____ Provider Name: _____ Health Insurance:_____

Place of Birth City: _____State: _____Country:_____

Employment Status (Check One):	Do you need help paying for prescriptions?
☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed ☐ Self-Employed	☐ Yes ☐ No

Please choose from the following:
☐ I have filed my federal income tax return. **If return filed:** ☐ Single or ☐ Joint
☐ I was **not** required to file federal income taxes for 2016.

Household Information

- Any person living in your household, other than yourself, must be listed below. Please list all dependents, the sliding fee is based on your household income and your family size.
- A Dependant is any person living in your household which you supply at least 50% of their support or income, and that you claim on your income tax return.

Name	*Medical/Dental ID #: Office Use Only*	***Date of Birth***	***Insurance***
Spouse _____	_____	_____	_____
*Other/Child*_____	_____	_____	_____
*Other/Child*_____	_____	_____	_____
*Other/Child*_____	_____	_____	_____

I attest that all of the information on this application, including annual gross income are complete and accurate to the best of my knowledge.

Signature_____ **Date** _____

Office Use Only:

Medical Patient ID	Dental Patient ID	Slide Level	Annual/90	Change in Income
_____	_____	_____	_____	_____

MEDICAL SLIDING FEE SCHEDULE

EFFECTIVE MAY 1, 2017

	Nominal Charge 100% Poverty and Below	Poverty 125%	150%	175%	200%	Over 200% of Poverty
Family Size	**$10.00 A**	**$20.00 B**	**$35.00 C**	**$45.00 D**	**$50.00 E**	**Full Charge**
1	$0 - $12,060	$12,061– $15,075	$15,076 - $18,090	$18,091- $21,105	$21,106 - $24,120	$24,121
2	$0 - $16,240	$16,241 - $20,300	$20,301 - $24,360	$24,361- $28,420	$28,421- $32,480	$32,481
3	$0 - $20,420	$20,421 - $25,525	$25,526 - $30,630	$30,631- $35,735	$35,736 - $40,840	$40,841
4	$0 - $24,600	$24,601 - $30,750	$30,751 - $36,900	$36,901- $43,050	$43,051- $49,200	$49,201
5	$0 - $28,780	$28,781 - $35,975	$35,976 - $43,170	$43,171 - $50,365	$50,366 - $57,560	$57,561
6	$0 - $32,960	$32,961 - $41,200	$41,201- $49,440	$49,441- $57,680	$57,681 - $65,920	$65,921
7	$0 - $37,140	$37,141 - $46,425	$45,426 - $55,710	$55,711 - $64,995	$64,996 - $74,280	$74,281
8	$0 - $41.320	$41,321 - $51,650	$51,651 - $61,980	$61,981 - $72,310	$72,311 - $82,640	$82,641

NOTE– FOR FAMILIES WITH MORE THAN 8 MEMBERS, ADD $4,180.00 FOR EACH ADDITIONAL MEMBER.
**Certain items provided within a visit(s) cannot be discounted; these include but are not limited to:
Injected Medications, Durable Medical Equipment or supplies and Physical Therapy Aids

PAYMENTS MUST BE MADE AT TIME OF VISIT

DENTAL SLIDING FEE SCHEDULE

**Based on eligibility, the patient is responsible for the percentage listed of the total charge.
For example: approved slide B, Diagnostic Visit is $90 (B= 40% X 90.00= $36 patient responsibility);
Patient responsibility would be $36**

Poverty Level	**DIAGNOSTIC AND PREVENTATIVE** Exams, Cleanings, Sealants	**BASIC** Restorative, Periodontal Treatment
A **	$15	$15
B	40%	50%
C	60%	65%
D	75%	80%
E	80%	90%
Over 200% of poverty– full charge	100%	100%

**** All patients below 100% of Poverty Guidelines will be charged the nominal fee of $15 or less based on demonstrated ability to pay.**

DIAGNOSTIC AND PREVENTATIVE procedures include: exams, cleanings, x-rays, and sealants.

BASIC procedures include: fillings such as with amalgam (silver) or composite (white), any gum treatments such as scaling and root planning (deep cleaning) and non-surgical simple extractions.

OPTOMETRY VISIT SLIDING FEE SCHEDULE

Based on eligibility, the patient is responsible for the percentage listed of the total charge. For example: approved slide B, New Patient Eye Exam is $176 (B= 35% X 176.00= $61.60 patient responsibility); Patient responsibility would be $61.60

Poverty Level	Visit Charge
A **	$20
B	35%
C	50%
D	75%
E	85%
Over 200% of poverty– full charge	100%

**** All patients below 100% of Poverty Guidelines will be charged the nominal fee of $20 or less based on demonstrated ability to pay.**

SLIDING FEE DISCOUNT FOR EYEGLASS PURCHASES

All KVHC patients with an approved sliding fee will receive a discount of 15% on one pair of eyeglasses annually through our Classic Optical basic package option.

If a patient has a demonstrated need for a second pair of eyeglasses the discount of 15% will be applied to the basic package option.