



Important!

How the Sliding Fee Program works

What is the Sliding Fee Program (Affordable Care Plan)?

- Patients in our Sliding Fee Program can get discounts for many services.
- Visit fees are on a sliding scale based on household income and size.
- Federal poverty guidelines set income ranges for this program.
- We can also help you find health insurance options through MaineCare or the Federal Health Insurance Marketplace.
- The Sliding Fee Program used to be called the Affordable Care Plan.
- The Sliding Fee Program is NOT health insurance.

Which services are covered and which are not?

- **Only PCHC visits are covered.** This includes visits for PCHC primary care, mental health, physical therapy, specialty services, or preventive dental care.
- Certain medical equipment, restorative dental care, infusion services, dentures, and hearing aids are not covered. Call 207-992-9200 x2005 if you have questions about covered services.
- Please ask outside healthcare providers if they offer a discount program.

How do I apply and get started with the program?

- Ask staff at the front desk for an application or go to www.PCHC.com/ACP to learn more. We also have specialists that can help you apply.
- Apply at or before the first visit when you are unable to pay. This may be when you are a new patient or when you face hard times, such as losing a job.
- Don't wait to apply! We cannot offer discounts for services you got before you signed your application.
- When you apply, you must send us all paperwork within 30 days or ask for an extension before that time. If you do not, you must reapply.
- An application must be filled out for each adult.

Sliding Fee Program Application



Please fill in all the spaces below. If you do not have an employer or insurance, write "none."

Name: _____ Date of Birth: _____

Marital Status: _____ Phone Number: _____

Mailing Address: _____

Where you live, if different from mailing address: _____

Employer Name: _____ Tax Filer: Yes No

If you have insurance, write the name here: _____

Total Number of persons in your household: _____ Check if Veteran: (Active or Retired)

How to Apply for the Program:

- **Household income:**
 - Household income is based on all income earned by members of the home. The chart on page 3 shows income sources and documents needed.
 - All applicants must provide the first two pages of their most recent tax return.
 - Income will be figured using the most recent tax return, unless the patient has had a qualifying life event such as marriage, divorce, death of a wage earner, or gain or loss of a job (end of seasonal employment does not count as a life event). Proof of a qualifying life event is required.
 - Income may include any item listed on the Income Worksheet.
- **All required forms and documents must be submitted within 30 days of this application.** You may return forms in person to the front desk at your provider's office, fax forms to 207-992-2065, or mail to O & E Supervisor, P.O. Box 439, Bangor, ME 04402.
- **This program requires that you pay a visit fee (co-pay) at the time of each visit.** It is not free care.
- Applications for MaineCare and Maine Breast & Cervical Health are available. We can help you apply.
- This application only applies to the patient listed and any dependent children under 18 years old. A separate application must be filled out for each adult.
- **The application is effective on the date you sign and is good for one year.**

We're here to help! Monday - Friday 8am-4:30pm

Call 207-992-9200 x2005 with any questions.

PCHC's Outreach & Enrollment team can help you with these forms. We can also help you find health insurance options through MaineCare or the Federal Health Insurance Marketplace.

Sliding Fee Program Application



Members of Household Worksheet


Please list names and birthdates for you and all members of your household.

- If you file taxes or you are claimed as a dependent, your household is you and anyone else listed on the tax return.
- If you do not file taxes and are not claimed as a dependent by anyone else, your household is you, your spouse, and your children that live with you.

- For divorced/separated/joint custody parental relationships - dependent children may only be listed on one program application.
- Financially co-dependent unmarried couples living together with mutual children will be counted as one household
- All married couples will be counted as a household.

First and Last Name	Date of Birth	Relation to You Self, spouse, child, parent, etc.	Gross Income Before deductions	Income Source Job, Social Security, SSI, TANF, etc.
1.				
2.				
3.				
4.				
5.				
6.				

** Please list any additional household members on another sheet of paper.

<h2 style="margin: 0;">Sliding Fee Program Application</h2>	
Income Worksheet	

Please provide a copy of your most recent tax return and any other income statements listed below.

IF ANYONE HAS....	✓	Amount paid/ How often	YOU MUST PROVIDE COPIES OF
Wages from an employer			One month of most recent paystubs OR most recent paystub with employee start date and year to date income amount listed.
Self-Employment or Rental Income			Last year's tax return and <i>all</i> supporting schedules. Last 3 months rental receipts to show gross rental income.
Capital Gains, Dividends, Interest			Most recent tax filing

Unemployment Benefits			Unemployment benefit letter or Weekly Claims report showing current gross income. To request a letter, call 1-800-593-7660.
Workers' Compensation Benefits			Workers Compensation benefits award letter showing gross distribution.
Short/Long Term Disability Benefits			Most recent pay stubs showing gross income for disability benefits for the last three months.
Social Security or Disability Income (SSI/SSDI)			Current year award letter. You can request a copy of your benefit award letter by calling 877-405-1448.
Retirement benefits			Benefit letter or statement (if 401K, IRA, etc...) showing gross amount distributed.
(or pays) Alimony or Child Support			Record of payments received or copy of the court order. Record of payments paid (bank statement, copy of check, etc.)
TANF			Benefit determination letter
No Income			Statement of support

- I certify that all my answers are correct and complete as far as I know.
- I will tell PCHC about any changes in my health insurance or family income.
- I understand that if I give false information, I will be disqualified from the program.
- I understand that if I get medicine from a drug company program, I allow that company to review my medical record and application to check on this medicine for audit purposes.
- I understand that this program is NOT health insurance.

**** Patient signature date is the effective date.**

Patient Signature: _____ Effective Date: _____

O & E Specialist Signature _____ Date: _____

Sliding Fee Program Application



Statement of Support for Applicants with No Income

Patient Name: _____ Date of Birth: _____

Please check the box below that applies to you.

Signature of family member, friend or other is required if:

- I do not have income to support myself and either live with someone or have someone who supports my daily living expenses.
- I do not have income to support myself and I am homeless or couch-surfing.
- I do not have income and I am assisted by an agency for housing, food or other daily needs.
- I do not have income and am supported by savings

- I do not have income and am supported solely by Financial Aide (FAFSA)
- I have income to support myself but do not file a Federal Tax Return. Profit & Loss Statement Required.

Signature of shelter or housing staff is required if:

- I do not have income to support myself and am living in a shelter or transitional housing.

Patient Signature Date

Signature of Family Member, Friend or Other Relationship to you Date

Signature of Shelter or Transitional Staff Date

Sliding Fee Program



Fee Schedule

Program Fees by Federal Poverty Level Table

Federal Poverty Levels (FPL) are based on Income and Household Size

PCHC Services	Level 1	Level 2	Level 3	Level 4	Level 5	Over 200% of FPG
Primary Care Including PCHC Specialty, PCHC Lab testing & X-ray	\$10	\$25	\$35	\$45	\$55	Full fee
Preventive Dental	\$35	\$45	\$55	\$65	\$75	Full fee
Restorative/Other Dental	\$35	35% discount	25% discount	15% discount	5% discount	Full fee
Pharmacy Effective Feb. 1, 2019	40% discount of drug cost	35% discount of drug cost	30% discount of drug cost	25% discount of drug cost	20% discount of drug cost	Full fee

Primary Care includes: Family Medicine, Pediatrics, Geriatrics, Counseling, Lab services, OMT, Gynecology, Nutrition/Diabetes Education, Psychiatry, Podiatry, Audiology, Speech, Physical Therapy, Walk-In Care Services, Wound Care, Complementary and Alternative Medicine including Chiropractic, Acupuncture, Massage Therapy and Meditation.

Preventive Dental includes: Cleanings, Exams, Sealants, Root Planing, Perio Maintenance and Radiology.

Restorative/Other Dental includes: Fillings, Non-Surgical Simple Extractions, Palliative Care (temporary relief of pain), and LIMITED orthodontics.

**** Fees do not include certain medical supplies, equipment, vaccines, hearing aids, certain nursing home visits, Infusion services, Dental Lab fees, dental implants, root canals, dentures (complete or partial), surgical extractions, etc.**

Patient Information Form



Patient Name: _____ Date of Birth: _____

SSN: _____ - _____ - _____ Email: _____ Date: _____

Person(s) to notify in case of emergency: _____ Phone: _____
_____ Phone: _____

PCHC requires this information to receive the federal funding needed to support its mission of providing quality, affordable healthcare to all. The information you give is kept confidential (private).

Primary language: English French Spanish Sign Language Other: _____

Race: (Select All that apply) White/Caucasian American Indian/Alaska Native Asian Native Hawaiian
 African American Other Pacific Islander Other: _____

Hispanic/Latino: Yes No

Sexual Orientation: Straight or Heterosexual Lesbian, Gay, or Homosexual Bisexual Something Else
 Don't know Choose not to disclose

Gender at Birth: Male Female

Gender Identity: Male Female Gender queer/questioning Transgender male (female to male)
 Transgender female (male to female) Other Choose not to disclose

Housing status: Not homeless Homeless Public housing Transitional housing Permanent Supportive Housing
If Homeless, where do you stay? Shelter Doubled Up Street Other

Number of people living in your household (including you)? _____

Agricultural worker: Yes No If yes, which one: Migrant Seasonal

Military Veteran: Yes No

Household Income Range:

<input type="checkbox"/> \$0-\$10,000	<input type="checkbox"/> \$20,001-\$25,000	<input type="checkbox"/> \$45,001-\$50,000	<input type="checkbox"/> \$70,001-\$75,000
<input type="checkbox"/> \$10,001-\$15,000	<input type="checkbox"/> \$25,001-\$30,000	<input type="checkbox"/> \$50,001-\$55,000	<input type="checkbox"/> \$75,001-\$80,000
<input type="checkbox"/> \$15,001-\$20,000	<input type="checkbox"/> \$30,001-\$35,000	<input type="checkbox"/> \$55,001-\$60,000	<input type="checkbox"/> \$80,001-\$85,000
	<input type="checkbox"/> \$35,001-\$40,000	<input type="checkbox"/> \$60,001-\$65,000	<input type="checkbox"/> \$85,001-\$90,000
	<input type="checkbox"/> \$40,001-\$45,000	<input type="checkbox"/> \$65,001-\$70,000	<input type="checkbox"/> > \$90,001

RESPONSIBLE PARTY INFORMATION

Does the patient have an agent or legal guardian who makes decisions on their behalf? Yes No

If yes, Name of Person(s) Responsible for Patient: _____

Relation (Parent, Spouse, etc.): _____ Phone: _____

**If the patient is over 18 years old, please provide an Advance Directive, such as a Healthcare Power of Attorney.*

Patient Information Form



Nondiscrimination Statement for Patients

Discrimination is against the law. PCHC complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex (including pregnancy and sex stereotyping), gender identity, sexual orientation, or any other characteristic protected by law.

PCHC provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). PCHC provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact PCHC's Civil Rights Coordinator.

If you believe that PCHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex (including pregnancy and sex stereotyping), gender identity, sexual orientation, or any other characteristic protected by law, you can file a grievance with PCHC's Civil Rights Coordinator in person or by mail (103 Maine Avenue, Bangor, Maine 04401), by phone (207-992-9200), by fax (207-907-7077), or by email (civilrights@pchc.com). If you need help filing a grievance, PCHC's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1- 800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.htm>.

Language Assistance Services

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística

(Chinese) 注意 : 如果您使用繁體中文, 您可以免費獲得語言援助服務

(Cushite) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.

(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn

(Arabic) بالمجان لك تتوافر اللغوية المساعدة خدمات فإن، اللغة اذكر تتحدث كنت إذا: ملحوظة

(Mon-Khmer, Cambodian) យកចិត្តទុកដាក់ : ប្រសិនបើអ្នក និយាយភាសាខ្មែរ, បសវា ជំនួយ ភាសា ឌីជីថលឌួង

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad

(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung

(Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี

(Nilotic*) PID KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̄ kuka lëu yök abac ke cin wënh cuatë piny

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.

(Japanese) 注意事項 : 日本語を話される場合、無料の言語支援をご利用いただけます。

Language Assistance Services are free of charge.