MAILING ADDRESS
PO Box 72 Sanford, ME 04073

LOCATIONS
15 Oak St Springvale, ME 04083
207 490-6900 PHONE 207 459-2822 FAX

388 Somersworth Rd, N Berwick, ME 03906
207 676-2175

A division of York County
Community Action Corporation

SLIDING FEE SCALE – CONFIDENTIAL APPLICATION

Date: ___________________

Patient Name ____

Date of Birth _____/_____/_____

Parent Name (if patient is a minor) __________________________ Phone Number___________________________

Home Address ____ City________________ State_______ Zip ____________

Mailing Address (if different)________________________________ City________________ State_______ Zip ____________

Marital Status ____________________________________ **Patient's** Social Security # ________________________

Please list all persons living in the household

Name	Age	Relationship to Patient

INCOME: List all household income (for yourself, spouse and other dependents)

Wages $__________

Self Employment $__________

Unemployment $__________

Workers Comp $__________

SSI/Disability $__________

Alimony/Child Support $__________

Pension $__________

Veterans Benefits $__________

General Assistance $__________

TANF/Food Stamps $__________

Rental Income $__________

Proof of income is required.
Please provide all of the following that apply to you:

- If self-employed – three month Profit and Loss statement AND most recent tax return
- If working – 4 most recent paystubs from all employers, for each working person in the household.
- If you have zero income, complete the Zero Income Worksheet AND submit a letter explaining your financial situation.
- Other documents to show proof of income
- A denial letter from MaineCare for all children, pregnant women and disabled adults.

Please continue on other side

MONTHLY EXPENSES

	Amount	Past Due?		Amount	Past Due?
Housing (mortgage or rent)	$		Auto Payment	$	
Property Taxes	$		Food	$	
Utilities (Electric, Water, Sewer)	$		Fuel	$	
Cable/Internet	$		Medical expenses	$	
Phone/Cell Phone	$		Other	$	
Insurance	$		Other	$	

Do you currently have medical insurance? □ Yes □ No Company____________________________________

Do you currently have dental insurance? □ Yes □ No Company____________________________________

Have you received a denial letter from MaineCare in the past 90 days? □ Yes □ No

Have you applied for health insurance under the Affordable Care Act? □ Yes □ No

I request that Nasson Health Care make a determination of my eligibility for the sliding fee scale for health care services rendered by Nasson Health Care. I understand that the information I submit is subject to verification by Nasson Health Care. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial for the sliding fee scale eligibility, and I will be liable for full payment.

I affirm that the above and attached information is true and correct to the best of my knowledge. If I become eligible for the sliding fee scale, I am aware I will be responsible for any remaining balance for services received after the approved slide fee discount has been applied and will make payment at the time services are rendered unless other arrangements have been made.

APPLICANT SIGNATURE ____ DATE _________________________

For Office Use Only

in Household _________ Total Household Income _________________

______ Approved

______ Denied ______ Over Income ______ Missing Information

Patient Services Representative ____Date____________

______ 0%-100% FPL ______ Medical/MH only
______ 101%-150% FPL ______ MH only
______ 151%-175% ______ Dental only
______ 176%-200% ______ Medical/MH and Dental