NASSON Health Care

MAILING ADDRESS
PO Box 72 Sanford, ME 04073

LOCATIONS
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207 490-6900 PHONE 207 459-2822 FAX

A division of York County
Community Action Corporation

SLIDING FEE SCALE – CONFIDENTIAL APPLICATION

Date: _____

Patient Name _____ Date of Birth _____/_____/_____

Patient's Social Security # _____ Phone number _____

Home Address _____ City_____ State_____ Zip _____

Mailing Address (if different)_____ City_____ State_____ Zip _____

Parent/Legal Guardian Name (if patient is a minor) _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Partnered

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

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

Have you applied for MaineCare in the past 90 days? □ Yes □ No

What is your current employment status?
☐ Employed Full Time
☐ Employed Part Time
☐ Unemployed and seeking work
☐ Otherwise unemployed, but not seeking work *(ex. Student, Retired, Disabled, unpaid primary care giver)*
If otherwise unemployed, please indicate reason _____

Proof of income is required.

Please provide all of the following that apply to you:

- If working – 4 most recent paystubs from all employers, for each working person in the household.
- If self-employed – three month Profit and Loss statement AND most recent tax return
- If receiving a monthly benefit like social security or a pension, documentation of monthly amount is required.
- 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

HOUSEHOLD AND INCOME: List all persons living in your household and income received (for yourself, your spouse and other legal dependents)

First and Last Name List the applicant first	**Age**	**Relationship to you**	**Gross income** (per month before deductions)	**Income source(s)** **Please list all that apply** Wages, Self-Employment, Unemployment, Workers' comp, Social Security, SSI, Disability, Alimony, Child Support, Pension, Veterans Benefits, Rental Income
1		*self*		
2				
3				
4				
5				
6				

Does your household receive any of the following benefits?
General Assistance/Food stamps/ TANF $_____ per month (please attach copy of letter showing benefits)

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 understand that I may be asked to provide more information, including household expenses.

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
_____ 101%-150% FPL
_____ 151%-175%
_____ 176%-200%

_____ Medical/MH only
_____ MH only
_____ Dental only
_____ Medical/MH and Dental