



KATAHDIN VALLEY HEALTH CENTER

30 Houlton Street
P. O. Box 500
Patten, ME 04765

Phone: 207-528-2285
Fax: 207-528-2880
E-mail: kvhc@kvhc.org

You may be eligible for a sliding fee discount—even if you have insurance!

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

Please take the time to complete and sign the sliding fee application. We require the following information be submitted **within 5 business days** of your appointment to determine your eligibility for the sliding fee discount. If documentation is not received in that time frame, you will be responsible for the entire bill.

- Signed 2010 Federal Income Tax Return (both signatures if filed jointly)
W-2 forms cannot be accepted If you are self employed submit any pertinent schedules (C, D, or F)
- If you do not have your 2010 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/article/0,,id=110571,00.html>

OR

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

- 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.)
- Four consecutive current pay stubs
- Social Security Checks
- Unemployment Statement
- Three months of bank statements showing direct deposit of income
- TANF Statement

If you have any questions regarding the sliding fee application process, please feel free to contact our patient assistance specialists at 1-866-366-5842 extension 325 for Patten, Millinocket, or Island Falls patients or extension 107 for Houlton patients.

Thank you,

Megan Day & Lynn Appleton
KVHC Patient Assistance Specialists

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



Katahdin Valley Health Center
PO Box 500
Patten, Maine 04765
(207)528-2285

2011 SLIDING FEE APPLICATION

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

Name: _____

Office use only:

Patient ID #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Health Insurance: _____

Employment Status (Check One):

Full-Time

Part-Time

Employer: _____

Retired

Disabled

Unemployed

Please choose one of the following:

I was required to file income taxes for the most current tax year.

I was not required to file income taxes for the most current tax year.

Would you like information on Prescription Assistance Programs?

Yes No

Dependant Information

A dependant is any person living in your household which you supply at least 50% of their support or income, and which you can claim on your income tax return.

List names and dates of birth for all dependants, including yourself:

Name:	<i>Office use only:</i> Patient ID #:	Date of Birth:	Insurance <i>(if different than above):</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Office use only:

Notes: _____

KATAHDIN VALLEY HEALTH CENTER MEDICAL SLIDING FEE SCHEDULE

EFFECTIVE MAY 1ST 2011

Family Size	Nominal Charge 100% Poverty and Below	Poverty Partial Charge				Over 200% of Poverty
	\$10.00	\$20.00	\$35.00	\$45.00	\$50.00	Full Charge
1	\$0 - \$10,890	\$10,891 - \$13,612	\$13,613 - \$16,335	\$16,336 - \$19,057	\$19,058 - \$21,780	\$21,781
2	\$0 - \$14,710	\$14,711 - \$18,387	\$18,388 - \$22,065	\$22,066 - \$25,742	\$25,743 - \$29,420	\$29,421
3	\$0 - \$18,530	\$18,531 - \$23,162	\$23,163 - \$27,795	\$27,796 - \$32,427	\$32,428 - \$37,060	\$37,061
4	\$0 - \$22,350	\$22,351 - \$27,937	\$27,938 - \$33,525	\$33,526 - \$39,112	\$39,113 - \$44,700	\$44,701
5	\$0 - \$26,170	\$26,171 - \$32,712	\$32,713 - \$39,255	\$39,256 - \$45,797	\$45,798 - \$52,340	\$52,341
6	\$0 - \$29,990	\$29,991 - \$37,487	\$37,488 - \$44,985	\$44,986 - \$52,482	\$52,483 - \$59,980	\$59,981
7	\$0 - \$33,810	\$33,811 - \$42,262	\$42,263 - \$50,715	\$50,716 - \$59,167	\$59,168 - \$67,620	\$67,621
8	\$0 - \$37,630	\$37,631 - \$47,037	\$47,038 - \$56,445	\$56,446 - \$65,852	\$65,853 - \$75,260	\$75,261

NOTE- FOR FAMILIES WITH MORE THAN 8 MEMBERS, ADD \$3,820.00 FOR EACH ADDITIONAL MEMBER.

**Certain items provided within a visit(s) cannot be discounted; these include but are not limited to:

Select Adult Vaccines, Injected Medications, Durable Medical Equipment or supplies and Physical Therapy Aids

PAYMENTS MUST BE MADE AT TIME OF VISIT

I attest that the annual gross income amounts I have provided are accurate to the best of my knowledge.

Signature: _____ **Date:** _____

	<i>Office Use Only</i>	<u>Yearly Income</u>
Income Tax Return (1040 Wages)		\$ _____
Income Tax Return (1040 Other Income)		\$ _____
Income Tax Return (Schedule C, E or F)	\$ _____ <i>(multiply by 30%)</i>	\$ _____
Social Security Statement		\$ _____
Unemployment Statement (Weekly Amount)	\$ _____ <i>(multiply by 52)</i>	\$ _____
Bank Statements (3 months-Average Monthly Balance)	\$ _____ <i>(multiply by 12)</i>	\$ _____
Other income not listed above		\$ _____
TOTAL HOUSEHOLD ANNUAL GROSS INCOME		\$ _____
SLIDING FEE LEVEL _____		
Approved by: _____	<i>Patient Enabling Coordinator</i>	Date: _____
Approved by: _____	<i>Office Manager</i>	Date: _____