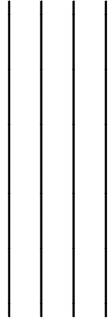


East Grand Health Center
201 Houlton Road
Danforth, Maine 04424
United States



Who should I contact if I have questions?

We understand that healthcare and the costs associated with it can be difficult to navigate. That's why our Patient Access Coordinator, Victoria Williams, is available to answer any questions that you might have. Reach out to Victoria by calling EGHC at (207) 448-2347 or by emailing victoria.williams@eastgrand.org.

Sliding Fee Discount Program:

Information and Application

We get it; healthcare is expensive.

East Grand Health Center offers comprehensive primary care services at a significantly discounted rate for those who qualify. At EGHC, all patients are eligible to be seen regardless of their ability to pay.

What is a sliding fee discount?

The Sliding Fee Discount Program allows us to adjust the cost of a patient's visit as determined by their income, whether **self-declared** or (**preferably**) **verified** by submitting pay stubs, tax returns, etc.

Which services are covered by the sliding fee discount?

All services that East Grand provides are eligible to be discounted under the Sliding Fee Discount Program.

What if I have health insurance?

Patients who have health insurance are eligible (and encouraged!) to apply. Having health insurance does not disqualify you from applying for the Sliding Fee Discount Program.

How is family defined? Can I count people who live with me as family members?

A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same house or apartment; they would all be considered members of a single family.

How is income defined?

Income is defined as earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income is comprised of earnings.

How do I know if I am eligible?

Eligibility for the Sliding Fee Discount Program is determined by family size and total income. As a Federally-Qualified Health Center, East Grand Health Center is able to offer discounted services for those whose income falls within the Federal Poverty Guidelines outlined in the Sliding Fee Eligibility Table below:

Number of people in your family	Sliding Fee Eligibility Table								
	Nominal Charge 100% Poverty and Below	101% - 199% Poverty Partial Charge							Full charge 200% Poverty and Above
Family Size	\$15.00	25% Of Charge		50% Of Charge		75% Of Charge		Full Charge	
1	0	12,140	12,141	15,175	15,176	18,210	18,211	24,279	24,280
2	0	16,460	16,461	20,575	20,576	24,690	24,691	32,919	32,920
3	0	20,780	20,781	25,975	25,976	31,170	31,171	41,559	41,560
4	0	25,100	25,101	31,375	31,376	37,650	37,651	50,199	50,200
5	0	29,420	29,421	36,775	36,776	44,130	44,131	58,839	58,840
6	0	33,740	33,741	42,175	42,176	50,610	50,611	67,479	67,480
7	0	38,060	38,061	47,575	47,576	57,090	57,091	76,119	76,120
8	0	42,380	42,381	52,975	52,976	63,570	63,571	84,759	84,760

*For families with more than eight members, add \$4,180.00 for each additional person

Please detach this application along the dotted line and return using the provided envelope:

Sliding Fee Discount Program Application

Name: _____ Date of Birth: _____ Phone #: _____

Address: _____ Health Insurance and Policy # (if applicable): _____

Other Members of Applicant's Family:

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Total # of Family Members (including Applicant): _____

Using the Sliding Fee Eligibility Table from the previous page, what is the Total Family Income? _____

PROOF OF INCOME (EX: TAX RETURNS, PAY STUBS, W-2, ETC.) MUST BE INCLUDED TO BE CONSIDERED FOR THE SFDP

I, the undersigned applicant, attest that I have reported true and accurate financials for my family to the best of my knowledge.

Signature of Applicant: _____ Date: _____

FOR EGHC USE ONLY: Received By: _____ Date: _____ Approved (Y/N): _____