HRCHC Affordable Care Application 2019 **Health/Dental Center Name: ________________________________**

This is an application for the sliding fee program at HealthReach Community Health Centers. This program offers a discount on services provided at our health/dental centers. This is not an insurance program.

A) Your information: (Applicant)

Name: **Mailing Address:**

Phone:

B) List yourself and family/household members

Name	DOB	Relationship	Income	Applying for Program
1.			Y N	Y N
2.			Y N	Y N
3.			Y N	Y N
4.			Y N	Y N
5.			Y N	Y N
6.			Y N	Y N
7.			Y N	Y N

Proof of Income

1) **Are you Employed?** **No ____** **Yes ____** (if yes send one of the four items listed below)
- The first 2 pages of your most recent Federal Income Tax return, or
- W-2 form, or
- Recent 2 consecutive pay stubs, or
- A letter from employer with address and phone number of employer, stating that you are an employee and the gross weekly income paid to you

Important note: Please send average pay stubs, and indicate if paid weekly, bi-weekly or other. If you are a seasonal worker, please note average weeks worked.

2) **Are you Self Employed?** **No ____** **Yes ____** (if yes send one of the items listed below)
- First 2 pages of 1040 of your most recent Federal Income Tax return
- Or last 3 months profit and loss statement.

3) **Are you receiving Unemployment Benefits?** **No ____** **Yes ____** (if yes send the item listed below)
- Notice from Department of Labor showing maximum benefit amount, the first letter you received.

4) **Do you receive other Income?** **No ____** **Yes ____** (send all items listed below that apply)
- Social Security: Recent social security notice or copy of bank statement showing direct deposit.
- Pensions: Copy of recent checks
- Child Support/Alimony: Copy of legal document or recent check payable.
- TANF copy of benefit amount
- Interest on Savings/Earnings
- Disability benefit notice
- Worker's compensation notice
- Widows benefit income notice
- Other income from miscellaneous sources (example: rental income)

5) If you receive **NO** financial assistance and have **NO** income, please provide a signed letter from the family member or friend providing your support. If you have no one assisting you, please provide a written explanation of how your living expenses are paid.

If you would like help applying for MaineCare, Care Partners, Breast and Cervical Health Program, hospital free care or the Health Insurance Marketplace circle **YES**

PENALTIES FOR MISREPRESENTATION: I certify that all of the information is true and correct and that all income is reported. I understand that this information is being provided for the receipt of Federal funds; that institution officials may verify the information on the statement and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

X____ ________________________

Applicant's Signature (or advocate) Date:

HealthReach Community Health Centers' Affordable Care Program FAQs

1) **How soon will a decision be made?**

- The application will be processed within 5 business days.
- The 1st day of the month the application is approved will be the effective date.
- As long as there is no change in your income or family size, the level of discount is good for 12 months.
- You will be notified by mail when it is time to renew your application.

2) **What is the applicants' responsibility?**

- It is your responsibility to notify us immediately in writing if your income or family size changes.
- It is your responsibility to notify us as soon as possible of any address changes.

3) **What does the HealthReach Affordable Care Program Cover?**

- Visits to any HealthReach Health or Dental Center
- Supplies used at Health Center visits
- If you are hospitalized, hospital visits by the Health Center Doctor
- Lab tests performed and lab specimens collected at the Health Center - you will receive a separate bill for any lab tests sent out to be processed (NorDx Lab)

Bring this form to your health or dental center with:

- Signature
- Proof of Income

Or mail it to:

HealthReach Community Health Centers
Attn: Patient Billing
PO Box 727
Waterville, ME 04903-0727

Telephone: (207) 660-9922 option 1
Toll Free: 1-800-299-2460

Your Fees Will Be Reduced if:	
Your family size is	and your family's income is less than:
1	$24,981
2	$33,821
3	$42,661
4	$51,501
5	$60,341
6	$69,181
7	$78,021
8	$86,861