HRCHC Affordable Care Application 2024 ***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 **– see FAQs for definition of household.**

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

Proof of Income

1) **Are you Employed? No ____ Yes ____** (if yes send one of the below)
   - The first 2 pages of your most recent Federal Income Tax return -Adjusted Gross Income
   - W-2 form- Gross Income
   - Recent 2 consecutive pay stubs *Indicate if paid weekly, bi- weekly, etc.– Gross Income

   Important note: If you are a seasonal worker, please note average weeks worked.

2) **Are you Self Employed? No ____ Yes ____** (if yes send one of the below)
   - First 2 pages of 1040 of your most recent Federal Income Tax return
   - Or last 3 months profit and loss statement. Call 660-9922 to request P&L sheet if need be.

3) **Are you receiving Unemployment Benefits? No ____ Yes ____** (if yes send the 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.
   - Disability benefit notice
   - Worker's compensation notice
   - Widows benefit income notice
   - Other income from miscellaneous sources (example: rental income, TANF, Interest, Dividends)

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.

6) Any requests for exceptions to these guidelines must be made in writing and require approval by the Revenue Cycle Manager and/or Director of Finance

If you would like help applying for MaineCare, 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
   - 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)

4. **What is a household?**
   Household refers to all persons related by birth, marriage, or adoption who reside together, dependents, and others in the same tax household. Individuals who are 19 or older and not dependents living at the same address are considered separate households. The following compose the household:

   - The applicant
   - Spouse
   - Domestic Partner when the applicant provides greater than 50% of the financial support (necessary living expenses) of the domestic partner.
     - Domestic Partnerships are defined as two individuals who are unmarried, 19 years or older, and who reside together.
   - Anyone under 19 years of age who lives with and is supported by the applicant.
   - Anyone claimed as a dependent on the applicant's federal tax return.
   - Anyone who claims the applicant on a federal tax return or is their tax dependent. If applicant is claimed as a dependent on a federal tax return, then the person(s) who claimed the applicant is considered part of the household and income verification is required.

Bring this form to your health or dental center signed and with proof of income.

Or Email it to: PatientAccounts@Healthreach.org (note: this is an unsecure email account)

Or through the patient portal (secure) click on "I have a HealthReach billing question" and attach your documents and note sliding fee application in the subject line.

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	$30,121
2	$40,881
3	$51,641
4	$62,401
5	$73,161
6	$83,921
7	$94,681
8	$105,441

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