SCRFHC Sliding Fee Application

Proof of income must accompany this application. If you do not have your income tax return, paycheck stubs, W-2's, employment check stubs, etc. with you, please keep this application and return with the proper forms to:

St. Croix Regional Family Health Center
136 Mill Street, Princeton, ME 04668

Date: ______________________________________

Name: ____

Address: ____

Telephone: _________________________________ Cell Phone: ________________________________

Employer: ____

Health Insurance: ______________________________________ Policy number: __________________

I understand that SCRFHC receives Federal funding and provides discounts to patients who qualify based on income and family size.

I understand that these discounts are only for patients who meet eligibility criteria established by the Federal Government. I understand that if I qualify for discounted services they will be provided to me as long as I continue to qualify. I agree to inform SCRFHC of any substantial change in my financial status that could prevent me from being eligible for the discount. I also agree to provide updated proof of income at future visits upon request.

I understand that SCRFHC requires a minimum fee of $20.00 at each visit, and I am expected to pay the minimum fee and any other charges when requested. If I am eligible for Medicare part B or private insurance coverage, I may also be eligible for the SCRFHC Sliding Fee Discount Program. However, discount will only be applied to balances after third party payments or assignments.

I understand that I am responsible for all charges billed to me not covered by third party payors, and that SCRFHC may refuse to provide non-emergency medical services and may engage a collection agency to collect from me if I fail to make timely payments. Knowing there limitations, I hereby request discounted medical services at SCRFHC.

Please list names and dates of birth for all household members, including yourself:

Name:	***Date of Birth***

Did you file an income tax for the previous year ________ Yes __________ No

☐ I attest that all the information, including the attached proof of income, is true and accurate.

Signature: ____ Annual Gross Income: ___________

Based in the above information, you are eligible for a sliding fee adjustment of: ___________________%.

Approved by: ____ Date: ______________________

SCRFHC is an equal opportunity provider and employer.

Hearing/Speech impaired, please call the Maine Telecommunications Relay Service at 711.