

Sliding Fee Scale Discount Program 2026 Guidelines

Sliding fee calculations are determined by using Federal Income Tax forms, last 30 days of paycheck stubs or unemployment verification. The below table is used to calculate eligibility.

Qualifications for the Sliding Fee Discount Scale are based on two factors: household size and income. In order to determine whether you will qualify for a discounted fee, follow the directions below.

1. Find the row on the chart that lists the number of individuals in your household. This number should include yourself, your spouse/partner, children and any other occupants of the household.
2. Next find your gross income to determine eligibility for the program.

NUMBER IN HOUSEHOLD	ANNUAL HOUSEHOLD INCOME EQUAL TO OR BELOW				
	LEVEL A Nominal Fee \$20	LEVEL B You Pay 25% or \$40 Minimum	LEVEL C You Pay 50% or \$45 Minimum	LEVEL D You Pay 75% or \$50 Minimum	LEVEL E 100% No Discount*
1	\$15,960	\$15,961 - \$21,226	\$21,227 - \$26,653	\$26,654 - \$31,920	\$31,921 & above
2	\$21,640	\$21,641 - \$28,781	\$28,782 - \$36,138	\$36,139 - \$43,280	\$43,281 & above
3	\$27,320	\$27,321 - \$36,335	\$36,336 - \$45,624	\$45,625 - \$54,640	\$54,641 & above
4	\$33,000	\$33,001 - \$43,890	\$43,891 - \$55,110	\$55,111 - \$66,000	\$66,001 & above
5	\$38,680	\$38,681 - \$51,444	\$51,445 - \$64,595	\$64,596 - \$77,360	\$77,361 & above
6	\$44,360	\$44,361 - \$58,998	\$58,999 - \$74,081	\$74,082 - \$88,720	\$88,721 & above
7	\$50,040	\$50,041 - \$66,553	\$66,554 - \$83,566	\$83,567 - \$100,080	\$100,081 & above
8	\$55,720	\$55,721 - \$74,107	\$74,108 - \$93,052	\$93,053 - \$111,440	\$111,441 & above
	100% of Poverty Guideline Level	101%-133% of Poverty Guideline Level	134%-167% of Poverty Guideline Level	168%-200% of Poverty Guideline Level	Over 200% of Poverty Guideline Level
For families/households with more than 8 persons, add \$5,680 for each additional person.					

***If you do not qualify for levels A-D of our clinic sliding fee discount, you may still qualify for our 340B screened pricing at our in-house pharmacy. Applicants with income at 500% or less of the Federal Poverty Level are eligible for a discount.**

340B SCREENED PRICING	
NUMBER IN HOUSEHOLD	ANNUAL INCOME
1	Up to \$79,800
2	\$79,801 - \$108,200
Each Additional Dependent	Add \$24,400

BUCKSPORT

110 Broadway ~ Bucksport, Maine 04416
(207) 469-7371

ELLSWORTH

37 Commerce Park ~ Ellsworth, Maine 04605
(207) 667-5064



SLIDING FEE DISCOUNT APPLICATION

It is the policy of Bucksport Regional Health Center (BRHC) to provide exceptional services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Your household discount will be assessed on a yearly basis or if your financial situation changes. Please complete the following information and return to the Billing Department to determine if you or members of your family are eligible for a discount.

HEAD OF HOUSEHOLD NAME:	PHONE:
DATE OF BIRTH:	PLACE OF EMPLOYMENT:
PHYSICAL ADDRESS:	
FAMILY SIZE: _____ (NUMBER OF MEMBERS LIVING IN YOUR HOUSEHOLD.) List name(s) and date(s) of birth of family members/individuals living in your household or individuals for whom you are financially responsible.	
Name: (Self)	Date of Birth
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
DO YOU HAVE INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Please Provide Medical Plan Name:	
DO YOU RECEIVE ANY OF THE FOLLOWING:	
<input type="checkbox"/> Food Stamps <input type="checkbox"/> Fuel Assistance <input type="checkbox"/> Low-Cost Drug Assistance <input type="checkbox"/> Housing Assistance	

SLIDING FEE DISCOUNT APPLICATION

PATIENT SLIDING FEE DISCOUNT PROGRAM CHECKLIST	
<p><u>APPLICATION</u></p> <p><input type="checkbox"/> Application Complete</p> <p><input type="checkbox"/> Application Signed</p>	<p><u>VERIFICATION CHECKLIST</u></p> <p><input type="checkbox"/> Proof of Residence: Driver's License -OR- Utility Bill</p> <p><input type="checkbox"/> Proof of Income:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Prior Year Tax Return</p> <p style="margin-left: 20px;"><input type="checkbox"/> Last 4 Weeks Pay Stubs</p> <p style="margin-left: 20px;"><input type="checkbox"/> SSI, Disability, Child Support</p> <p style="margin-left: 20px;"><input type="checkbox"/> Self-Affidavit</p> <p><input type="checkbox"/> Insurance Information</p>

THE FOLLOWING IS FOR BRHC USE ONLY:	
APPLICANT NAME:	<input type="checkbox"/> New Application <input type="checkbox"/> Renewal Application
DATE APPLICATION RECEIVED	
FAMILY SIZE	
HOUSEHOLD INCOME	
DISCOUNT RATE:	<input type="checkbox"/> Level A <input type="checkbox"/> Level B <input type="checkbox"/> Level C <input type="checkbox"/> Level D <input type="checkbox"/> Level E
EFFECTIVE DATE:	From: _____ To: _____
DATE LETTER SENT	
DATE ENTERED INTO EMR	

Health Access Coordinator

Date

Supervisor

Date

**SELF AFFIDAVIT OF INCOME & FAMILY SIZE LETTER
HAC PROGRAM (SLIDING FEE)**

PATIENT NAME:	
PATIENT'S DOB:	
PATIENTS ADDRESS	STREET/PO BOX
	TOWN STATE ZIP CODE
PATIENT'S PHONE:	
TODAY'S DATE:	

I am providing this self-affidavit letter to verify my income and family size as I have no other income documentation available to me.

AFFIDAVIT OF INCOME AND ZERO INCOME:

I, _____, declare that I receive \$ _____ (gross amount), and the frequency of pay is (weekly, every two weeks, twice per month). I last received this amount on _____.

Employers Name: _____

Employers Address: _____

If income is zero, all adult family members (over the age of 18) must complete and sign a Self-Affidavit.

I, _____, declare that I do not receive income from any source, including but not limited to; employment, unemployment, disability, child support, alimony, pension, Social Security retirement and/or disability benefits, etc.

AFFIDAVIT OF FAMILY SIZE

I certify that a total of _____ people (including, spouse, children, parents, grandparents, etc.) are living in my household.

- I certify that the information presented in this letter is true and correct to the best of my knowledge.
- I understand that this information will be used to determine my eligibility for a Sliding Scale Discount.
- I understand that I must report to BRHC any change that affects my income within 30 days of the change.

Signature of Person Receiving Income

Date

02-18-2026TLH