



## DFD Russell Medical Center Sliding Fee Discount Application

**Mail to:**  
180 Church Hill Rd. Ste.1  
Leeds, ME 04263

This application is available to all persons, uninsured or underinsured requesting discounted services under the DFD Russell Medical Center sliding fee for services program.

Name:	Telephone No.:
Address:	

Household Members:			Income (complete one column)		
	Name	Date of Birth	Weekly	Monthly	Annual
Self					
Spouse					
Children					

**Income requirement information:** This application requires some form of documented household supporting income. Include income from all sources for persons supporting household, wages, tips, Social Security income and benefits, pensions, annuities, alimony, child support, income from trusts or estates, military, unemployment, self-employment, income from public aid. This income information is confidential and will be used only for the evaluation completed by our finance staff. It will not be disclosed nor will it become part of any medical record.

1. **A complete copy of your last individual income tax return (1040 form). Include all schedules and attachments.**
2. **Two recent forms of employment income, such as pay stubs, or one social security, unemployment or other benefit check stub.**
3. **Maine Care benefits status Letter, if required.**

**Certification of Accuracy**

I certify that the information provided above is complete and accurate and that I have disclosed all sources of household income. I understand if it is later determined that I have materially misrepresented any of this information DFD Russell Medical Center has the right to bill me for discounts previously allowed and I agree to pay all such charges.

**If approved, sliding fee discounts are valid for one year from the date of approval.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**DFD use only:**

Centricity Number: \_\_\_\_\_

Date received: \_\_\_\_\_

Approved by: \_\_\_\_\_

Discount category: \_\_\_\_\_

Date Approved: \_\_\_\_\_

Date to Quest: \_\_\_\_\_