SPURWINK

Program Policy	
Applies to: Outpatient & Community Services Center for Safe & Healthy Families Effective: 5/21/1997 Revised: 12/10/01; 4/16/09; 1/19/10; 12/13/12; 07/14/16; 12/18/18; 02/20/19; 03/21/19; 9/29/23 Reviewed: Ref Code: COA, Client Rights (CR) 1.08 Related agency policies: Response to Termination of Funding; Fee Administration Policy	**FEE ASSISTANCE POLICY**

Policy: All clients that meet the income guidelines as defined by the Department of Health & Human Services in the state of Maine, and modified by Spurwink Services, will be eligible for consideration for Fee Assistance for services provided by the agency. Fee assistance will be made available to the extent possible within the agency's financial resources.

Requirements: Client, parent and/or guardian:

a. must meet Spurwink Services income guidelines.

b. must be willing and able to prove financial need.

c. must provide all possible payer information (i.e., copies of all health insurance cards).

d. must apply for MaineCare.

Process:

a. Application for assistance must be completed in its entirety

b. Proof of total household income must be provided (copies of last 3 paycheck stubs, SSI benefits, child support, etc.). Proof of income includes

- Child support payments (even if the parent does not choose to collect this support.)
- Divorce/separated parent's income (in lieu of child support documents).
- Wages for all adult wage earners in the home.
- Trust funds.
- All other sources of income.

c. The complete application will be reviewed by the Patient Account Manager and presented to the agency's Treasurer for approval/denial.

d. Applicant will be notified by the Patients Account Manager or the clinician where services are requested within a week of application review (application will be reviewed as soon as all copies of income sources are presented for complete review).

Decision Process:

a. If the applicant meets the requirement for 100% fee assistance the client will not be responsible for any balance that Spurwink Services is not able to collect from any other type of payer (i.e., group insurance, trust funds, etc.)

b. If the applicant is not within income guidelines for 100% fee assistance but can prove a financial need as required above, then partial financial assistance will be provided as indicated on the chart below. In this case, the client/guardian will meet to discuss this with the Patient Account Manager or his/her clinician.

SPURWINK

Spurwink Sliding Fee Scale Schedule for Outpatient Services

Family Size	1	2	3	4	5	6	7	8
Discount	Family Income	Family Income	Family Income	Family Income	Family Income	Family Income	Family Income	Family Income
100%	$ 29,160.00	$ 39,440.00	$ 49,720.00	$ 60,000.00	$ 70,280.00	$ 80,560.00	$ 90,840.00	$ 101,120.00
90%	$ 30,618.00	$ 41,412.00	$ 52,206.00	$ 63,000.00	$ 73,794.00	$ 84,588.00	$ 95,382.00	$ 106,176.00
80%	$ 32,148.90	$ 43,482.60	$ 54,816.30	$ 66,150.00	$ 77,483.70	$ 88,817.40	$ 100,151.10	$ 111,484.80
75%	$ 32,952.62	$ 44,569.67	$ 56,186.71	$ 67,803.75	$ 79,420.79	$ 91,037.84	$ 102,654.88	$ 114,271.92
70%	$ 34,600.25	$ 46,798.15	$ 58,996.04	$ 71,193.94	$ 83,391.83	$ 95,589.73	$ 107,787.62	$ 119,985.52
60%	$ 36,330.27	$ 49,138.06	$ 61,945.85	$ 74,753.63	$ 87,561.42	$ 100,369.21	$ 113,177.00	$ 125,984.79
50%	$ 38,146.78	$ 51,594.96	$ 65,043.14	$ 78,491.32	$ 91,939.49	$ 105,387.67	$ 118,835.85	$ 132,284.03
40%	$ 40,054.12	$ 54,174.71	$ 68,295.29	$ 82,415.88	$ 96,536.47	$ 110,657.06	$ 124,777.65	$ 138,898.23
30%	$ 42,056.82	$ 56,883.44	$ 71,710.06	$ 86,536.68	$ 101,363.29	$ 116,189.91	$ 131,016.53	$ 145,843.14
25%	$ 43,108.25	$ 58,305.53	$ 73,502.81	$ 88,700.09	$ 103,897.38	$ 119,094.66	$ 134,291.94	$ 149,489.22
20%	$ 45,263.66	$ 61,220.80	$ 77,177.95	$ 93,135.10	$ 109,092.24	$ 125,049.39	$ 141,006.54	$ 156,963.68
10%	$ 47,526.84	$ 64,281.84	$ 81,036.85	$ 97,791.85	$ 114,546.86	$ 131,301.86	$ 148,056.86	$ 164,811.87
0%	$ 49,903.18	$ 67,495.94	$ 85,088.69	$ 102,681.45	$ 120,274.20	$ 137,866.95	$ 155,459.71	$ 173,052.46

Revised 9/28/2023 based on 2023 Federal Poverty Guidelines for 200% of Federal Poverty Level

For families/households with more than 8 persons, add $10,280 for each additional person

SPURWINK

REDUCED FEE APPLICATION

Client Name: _____ Date: _____

Applicant Name: _____

Applicant's Mailing Address: _____ Phone: _____

_____

Does client/parent/guardian have private insurance? ☐Yes ☐No

Name of insured: _____

Name of insurance carrier _____ Insurance Number _____

Staff Instruction: Attach copy of the front and back of the insurance card.

Has parent/guardian applied for MaineCare for the client? ☐Yes ☐No
If "yes" MaineCare Number _____ If "no" explain, please explain why (note: not applying for MaineCare may disqualify you for reduced fee assistance).

_____

_____

Staff Instruction: If MaineCare was applied for and denied attach the MaineCare denial letter for the client.

Attach latest W-2 or three most recent pay stubs from each family member and supporting documentation for all other income sources. **All sources of income must be reported**. **Changes to family income must be disclosed immediately.** Failure to report changes in income will retroactively rescind any reduction in the fees. Check income sources included.

Income Source	Name of Recipient	Amount per Month
Employment		
Employment		
Child Support		
Social Security (☐SSI ☐SSDI)		
Public Assistance (☐TANF ☐Aspire ☐Gen. Asst.)		
Other Income (specify)		
#Adults in Household:	#Children in household: (Under age 18)	#Dependent Adults:

Total Monthly Family Income: _____ Yearly Average Income: _____

Consent to Verify Employment:
I hereby give permission for Spurwink Services to contact my employer to verify my earnings. All information provided is accurate, complete and reflects my current financial status.

Employment Contact Person: _____ **Phone**: _____

Client/Parent/Guardian Signature: _____ **Date**: ___/___/___

The above-named client has been approved for a reduction in the standard fee of ____%.

_____ ___/___/___ _____ ___/___/___
Chief Financial Officer Date Client or Guardian Date