

Sawtooth Mountain Clinic Sliding Fee Scale Program

What is Sawtooth Mountain Clinic’s Sliding Fee Scale Program?

The Sliding Fee Scale program is a federal program that permits Sawtooth Mountain Clinic to reduce the normal costs of medical, dental, mental health, and other services for patients who qualify. All patients are encouraged to apply for the Sliding Fee Scale program, whether or not they have insurance and regardless of immigration status. Eligibility for the Sliding Fee Scale program is based on:

- The number of people who live in your household (spouse/partner, children/dependents)
- The amount of money earned by the people in the household

How can the Sliding Fee Scale program help you?

The program reduces your cost for visits to Sawtooth Mountain Clinic, as well as for the following services (see next page for specific service providers):

- Pharmacy
- Lab, X-ray, Ultrasound
- Dental
- Vision

The Sliding Fee Scale program also reduces costs for the following **with a referral from your medical provider**:

- Physical Therapy
- Occupational Therapy
- Mental/Behavioral Health
- Hearing Aids
- Initial consultation with a specialist

How much will I pay for services if I am on the Sliding Fee Scale program?

How much you pay for services depends on your Sliding Fee Scale patient pay level and what services you have done. This can be found on page four. Sawtooth Mountain Clinic staff make the final determination on your level using the information you provide in your application. The following chart will help determine what level you qualify for:

| HOUSEHOLD SIZE | | A - 0% | | B - 10% | | C - 15% | | D - 20% | |
|----------------|----------|--------|----------|----------|----------|----------|----------|----------|-----------|
| | | 0% | 100% | 100.1% | 133.3% | 133.4% | 166.7% | 166.7% | 200% |
| 1 | \$15,960 | \$0 | \$15,960 | \$15,961 | \$21,280 | \$21,281 | \$26,600 | \$26,601 | \$31,920 |
| 2 | \$21,640 | \$0 | \$21,640 | \$21,641 | \$28,853 | \$28,854 | \$36,067 | \$36,068 | \$43,280 |
| 3 | \$27,320 | \$0 | \$27,320 | \$27,321 | \$36,427 | \$36,428 | \$45,533 | \$45,534 | \$54,640 |
| 4 | \$33,000 | \$0 | \$33,000 | \$33,001 | \$44,000 | \$44,001 | \$55,000 | \$55,001 | \$66,000 |
| 5 | \$38,680 | \$0 | \$38,680 | \$38,681 | \$51,573 | \$51,574 | \$64,467 | \$64,468 | \$77,360 |
| 6 | \$44,360 | \$0 | \$44,360 | \$44,361 | \$59,147 | \$59,148 | \$73,933 | \$73,934 | \$88,720 |
| 7 | \$50,040 | \$0 | \$50,040 | \$50,041 | \$66,720 | \$66,721 | \$83,400 | \$83,401 | \$100,080 |
| 8 | \$55,720 | \$0 | \$55,720 | \$55,721 | \$74,293 | \$74,294 | \$92,867 | \$92,868 | \$111,440 |

For households with more than 8 persons add \$5,680 for each additional person

How do I apply for the program?

Applying for the Sliding Fee Scale program is easy! Just pick up an application, fill it out, and return it to the clinic with proof of your income. Staff will review your application and determine if you qualify for the program and at what level.

Proof of Income

In order to qualify for the Sliding Fee Scale program, you will need to provide information about your family and your income. The proof of income must be returned to Sawtooth Mountain Clinic within 30 days of submitting the completed application. If you do not provide proof of income, your Sliding Fee Scale eligibility will end. **If you file taxes, we will need a copy of your last 1040.** If you do not file taxes, contact the Sliding Fee Scale Program coordinator for assistance.

How long do I stay on the Sliding Fee Scale program once I am approved?

Enrollment in the Sliding Fee Scale program is good from June 1st of a given year to the following May 31st. Federal poverty guidelines are updated annually on February 1st, which may affect your Sliding Fee Scale level. All participants need to reapply and update their income each spring to remain on the program. If you have household size or income changes, or would like a redetermination at any time, please contact Sawtooth Mountain Clinic and ask to speak to the Sliding Fee Scale Program coordinator.

Once my application is approved, what exactly will the Sliding Scale program cover?

CT Scan: When done at North Shore Health Hospital and ordered by a SMC provider

Consultation (Initial outpatient): When a referral is made by a SMC Provider

Dental: For medically necessary services provided by Grand Marais Family Dentistry, this does not include braces

Laboratory tests: At North Shore Health Hospital, must be ordered by a SMC Provider

Mental health/Behavioral Health Services: With a referral from a SMC Provider, visits may be scheduled with Kelly Senty, MS at Steps of Change

MRI: with Mobile Unit available at North Shore Health Hospital, when ordered by an SMC Provider

Physical and Occupational Therapy: At North Shore Health Hospital or with Becky Stoner, PT at the Grand Marais Wellness Center; PT and OT must be ordered by a SMC Provider

Prescription drugs: Prescriptions obtained at the Sawtooth Mountain Clinic Pharmacy in Grand Marais and Essentia Health Clinic in Silver Bay are covered when a SMC Provider writes the prescription. **Prescriptions are not covered** if they are written for items available over-the-counter, except for diabetic supplies – these are covered with a written prescription (yearly) from a SMC provider.

Primary health care services: Must see a provider or nurse at SMC

X-ray and diagnostic tests: At North Shore Health Hospital, must be ordered by a SMC Provider

Vision Care: Basic vision exams up to twice per year as necessary when performed by St. Luke's Ophthalmology Associates. Sliding Fee Scale will **NOT** cover eyeglasses or contact lenses.

Hearing Aid Assistance: For the purchase of low-cost hearing aids when arranged through hearing providers working with SMC; assistance will be reviewed on a case by case basis and must be pre-approved.

THE SLIDING FEE SCALE PROGRAM DOES NOT COVER massages, homeopathic services, emergency room, cardiac rehab, supplies, IV therapy, infusions, in-patient or observation at the hospital, nursing home charges, labor and delivery, prescriptions while in the North Shore Health Care Center, or as an in-patient. North Shore Health Hospital does have a Community Care program available for patients who qualify.

How does billing work?

Sawtooth Mountain Clinic will bill your insurance (if any). After insurance has been processed, you will be responsible for the amount after the Sliding Fee Scale is applied to the total charge. You will then be billed by Sawtooth Mountain Clinic for what you owe. See the Sliding Fee Scale Benefits by Service page for additional details.

The terms and limitations of the Sliding Fee Scale program are subject to change at any time.

If you need translation assistance, interpretive services are available in any language.

**For more information about the Sliding Fee Scale program,
call Sawtooth Mountain Clinic at 218-387-2330 and ask for Lynnea.**

Sliding Fee Scale Application 2026/2027

| Patient Information | | | | |
|----------------------------|-------------------------------|---|-----------------|------|
| First Name: | Middle Initial: | Last Name: | Previous Names: | |
| Mailing Address: | | City: | State: | Zip: |
| Cell Phone: () - | | Home Phone: () - | | |
| Date of Birth: / / | Social Security # - - | Do you have health insurance? Yes // No | | |
| Name of Insurance: | | | | |

| Family/Household Size: _____ | | | |
|------------------------------|---------------|---------------------|----------|
| Name of Household Member | Date of Birth | Relationship to You | Working? |
| | / / | | |
| | / / | | |
| | / / | | |
| | / / | | |
| | / / | | |
| | / / | | |

NOTE: To comply with federal regulations, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least yearly. Your yearly income tax return will be sufficient proof. Your annual income and family size will be used to calculate your discount level.

PLEASE ATTACH A COPY OF YOUR MOST RECENT FEDERAL TAX FORM 1040

| Family/Household Income | | | |
|-------------------------|---|-----------|--|
| 1 | Did you file a federal income tax form last year? | Yes // No | |
| 2 | If yes, what was your modified adjusted gross income (MAGI)? (see MAGI instructions on back) | \$ | |
| 3 | Do you expect your MAGI to be the same this year? | Yes // No | |

| Household Member | Amount | Frequency (Circle one) | Source of Income |
|-------------------|-----------|--------------------------------|------------------|
| You | \$ | Weekly Biweekly Monthly Yearly | |
| Is this seasonal? | Yes // No | If yes, how many months? | |
| Spouse/Other | \$ | Weekly Biweekly Monthly Yearly | |
| Is this seasonal? | Yes // No | If yes, how many months? | |
| Other | \$ | Weekly Biweekly Monthly Yearly | |
| Is this seasonal? | Yes // No | If yes, how many months? | |

| | |
|--|----------------------------------|
| TOTAL ANNUAL INCOME* OF HOUSEHOLD MEMBERS: \$ | (total must be filled in) |
|--|----------------------------------|

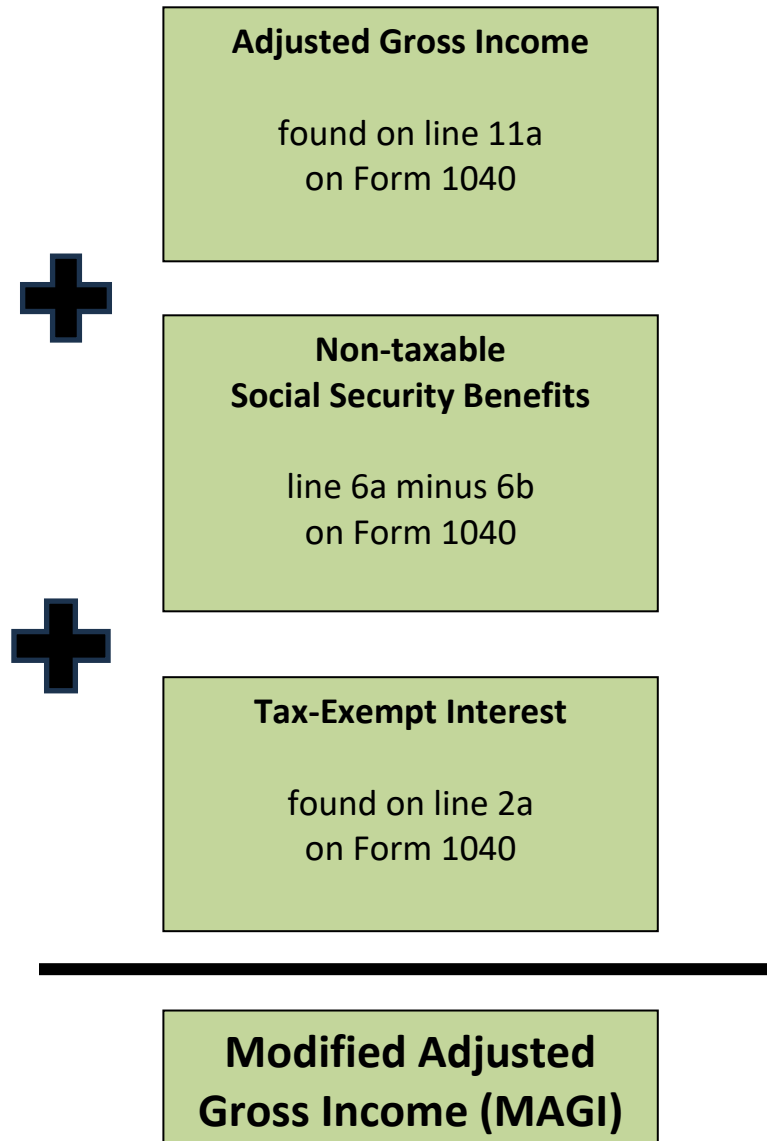
*if you cannot provide proof of income today, an estimate is fine, but proof is required within 30 days

| OFFICE USE ONLY |
|--------------------------------|
| Slide Level: _____ |
| Start Date: ____/____/____ |
| Term Date: ____/____/____ |
| Notes: _____ _____ _____ |
| Staff Initials: _____ |

I do hereby affirm that the information provided on this application is true and correct to the best of my knowledge. If acceptance in the Sliding Fee Scale program is obtained under this application, I will comply with all rules and regulations of the program. Sawtooth Mountain Clinic will not be responsible for bills which I may incur that are outside the scope of the Sliding Fee Scale Program. Sawtooth Mountain Clinic, Cook County North Shore Health, and Oral Health Task Force may share my information to determine program eligibility. I hereby acknowledge that I read the foregoing disclosure and understand it.

Signature: _____ **Today's Date:** ____/____/____

How to add up your Modified Adjusted Gross Income (MAGI) from your 2025 Tax Return (form 1040)



Sliding Fee Scale Service Chart - 2026/2027

Medical, Behavioral Health, other Approved Services (non-Pharmacy or Dental)

| | Level A | Level B | Level C | Level D |
|---------------------------|--------------|---------------|---------------|---------------|
| All Clinic Charges | 0% of charge | 10% of charge | 15% of charge | 20% of charge |

*Please note that for each level there is a minimum fee charged per appointment: a nominal \$5 fee for Level A and more than the nominal fee for B, C, & D Levels

Pharmacy - Uninsured Patients

| | Level A | Level B | Level C | Level D |
|----------------------|------------------------|-------------------------|-------------------------|-------------------------|
| 30 day supply | Acquisition Cost + \$5 | Acquisition Cost + \$10 | Acquisition Cost + \$15 | Acquisition Cost + \$20 |
| 90 day supply | Acquisition Cost + \$8 | Acquisition Cost + \$15 | Acquisition Cost + \$20 | Acquisition Cost + \$25 |

Pharmacy - Patients with Insurance Charges over \$30

| | | | | |
|--------------------------|--------------------------------|---------------------------------|---------------------------------|---------------------------------|
| All prescriptions | 5% of charge in excess of \$30 | 10% of charge in excess of \$30 | 15% of charge in excess of \$30 | 20% of charge in excess of \$30 |
|--------------------------|--------------------------------|---------------------------------|---------------------------------|---------------------------------|

Dental Services

| | Level A | Level B | Level C | Level D | |
|----------------------------|---|---------|---------|---------|-----|
| Category 1 Services | Exams, basic dental screenings and recommendations for preventative intervention | 0% | 10% | 15% | 20% |
| | Prophylaxis (cleanings) | 0% | 10% | 15% | 20% |
| | Periodontal maintenance (cleanings when gum disease is present) | 0% | 10% | 15% | 20% |
| | Topical application of fluorides and the prescription of fluoride for the systemic use when not available in the water supply | 0% | 10% | 15% | 20% |
| | X-rays | 0% | 10% | 15% | 20% |
| | Sealants | 0% | 10% | 15% | 20% |
| Category 2 Services | Restorative (fillings) | 10% | 20% | 30% | 40% |
| | Root canals of anterior (front) and pre-molar teeth | 10% | 20% | 30% | 40% |
| | Scaling and root planing (cleaning of calculus below the gumline - requires local anesthesia) | 10% | 20% | 30% | 40% |
| | Extractions | 10% | 20% | 30% | 40% |
| Category 3 Services | Root canals of posterior (molar) teeth | 40% | 50% | 60% | 70% |
| | Crowns | 40% | 50% | 60% | 70% |
| | Partials | 40% | 50% | 60% | 70% |
| | Dentures | 40% | 50% | 60% | 70% |
| | Reline Dentures, Occlusal guard, Athlete Multiguard, Aire Ease (sleep apnea) | 40% | 50% | 60% | 70% |
| Category 4 Services | Bridges | 50% | 60% | 70% | 80% |

*Please note that for each level there is a minimum fee charged per appointment: a nominal \$5 fee for Level A and more than the nominal fee for Levels B, C, & D

**Category 3 & 4 services require a 50% pre-payment by the patient to Grand Marais Family Dentistry