

## OUR LOCATIONS

ADMINISTRATIVE OFFICE  
101 Park Place  
Selma, Alabama 36701  
Telephone: 334-874-7428  
Fax: 334-874-7435

Marion Health Center  
1310 Washington St.  
Marion, AL 36756  
Telephone: 334-683-2073  
Fax: 334-683-2077

Demopolis Health Center  
1502 US Highway 80, Unit A  
Demopolis, AL 36732  
Telephone: 334-289-1193  
Fax: 334-289-1196

Dallas County Health Center  
228 Selma Ave  
Selma, AL 36701  
Telephone: 334-877-1490  
Fax: 334-877-1491

Thomaston Health Center\*  
111 Main St.  
Thomaston, AL 36783  
Telephone: 334-627-3497  
Fax: 334-627-3501

Uniontown Health Center  
330 Old Hamburg Rd.  
Uniontown, AL 36786  
Telephone: 334-628-2651  
Fax: 334-628-2656

Pine Apple Health Center  
867 County Rd. 59  
Pine Apple, AL 36768  
Telephone: 251-746-2197  
Fax: 261-746-2467

Yellow Bluff-Camden Health Center  
2210 Highway 221  
Camden, AL 36726  
Telephone: 334-682-5772  
Fax: 334-682-5792

## OUR SERVICES

Family Medicine  
Internal Medicine  
Women Health Care  
Men Health Care  
Child and Adolescent Health Care  
Dental Care  
Vision Care  
Podiatry Care  
Behavioral and Mental Health Care  
Substance Abuse Care  
Telemedicine  
Labs and Diagnostics  
X-ray  
Language Translation  
Case Management  
Social Services  
Patient Assistance Programs  
Pharmacy



NO INSURANCE?  
**SLIDING FEE  
PROGRAM**

IT'S GOOD TO  
HAVE **OPTIONS**

[WWW.RHMPI.COM](http://WWW.RHMPI.COM)

# NO INSURANCE?

## WE CAN HELP

Rural Health Medical Program, Incorporated ensures that no one will be denied access to quality health care services due to their inability to pay.

Our sliding-fee program allows us to reduce or "slide" the fees for the care that you and your family receive. You can apply for the program if you need assistance to help you pay for your care.

Eligibility is based on household income and family size. Your bill always will be at least \$15 for medical services; \$35 for dental, \$30 for vision, behavioral health, and podiatry; and \$10 for lab services. This minimum amount is due at the time of your visit, as well as payment for any other unpaid balances.

To apply for the sliding fee program, please provide your most recent pay stubs for the last 30 days, current personal income tax return, or an unemployment benefit statement.

You can visit one of our Community Health Centers or download the Sliding-Fee Application at our website: [www.rhmpi.com](http://www.rhmpi.com)

# SLIDING FEE Scale

Based on 2019 Federal Poverty Level (FPL) Guidelines

	CATEGORY A: <100% FPL	CATEGORY B: 101%-133% FPL	CATEGORY C: 134%-166% FPL	CATEGORY D: 167%-199% FPL
<b>MEDICAL</b>	<b>\$15</b>	<b>\$25</b>	<b>\$35</b>	<b>\$45</b>
<b>DENTAL*</b>	<b>\$35</b>	<b>\$45</b>	<b>\$55</b>	<b>\$65</b>
<b>VISION**</b>	<b>\$30</b>	<b>\$40</b>	<b>\$50</b>	<b>\$60</b>
<b>BEHAVIORAL HEALTH</b>	<b>\$30</b>	<b>\$40</b>	<b>\$50</b>	<b>\$60</b>
<b>PODIATRY</b>	<b>\$30</b>	<b>\$40</b>	<b>\$50</b>	<b>\$60</b>
<b>LAB TEST(S)</b>	<b>\$10</b>	<b>\$25</b>	<b>\$35</b>	<b>\$40</b>

\*Dental service fees presented above excludes the cost of any non-preventative care services, medications, and/or supplies.

\*\*Vision service fees presented above excludes the cost of specialty testing, contacts, and glasses.

## REQUIRED ELIGIBILITY DOCUMENTS

1) Proof of Income for the Last 30 Days: Physical document of any income you or a family member in the household may have. Examples pay stubs, child support, social security award letter, etc.

2) Proof of Address: Provide your most current utility bill with the applicant's name or spouse's name, or provide a statement from the person you are residing with.

3) Proof of Personal Identification: Provide original or legible copies of Photo I.D., Birth Certificates and Social Security Cards for everyone in the home.

4) Proof of Insurance: If any member of your household has private medical insurance, medicaid, or medicare, please provide a copy of their insurance card.

## HOUSEHOLD INCOME Family Size

FAMILY SIZE	A ≤ 100% FPL	B 101-133% FPL	C 134-166% FPL	D 167-199% FPL	E ≥ 200% FPL
1	\$0 - \$12,490.00	\$12,490.01 - \$16,611.70	\$16,611.71 - \$20,733.40	\$20,733.41 - \$24,980.00	≥\$24,980.01
2	\$0 - \$16,910.00	\$16,910.01 - \$22,490.30	\$22,490.31 - \$28,070.60	\$28,070.61 - \$33,820.00	≥\$33,820.01
3	\$0 - \$21,330.00	\$21,330.01 - \$28,368.90	\$28,368.91 - \$35,407.80	\$35,407.81 - \$42,660.00	≥\$42,660.01
4	\$0 - \$25,750.00	\$25,750.01 - \$34,247.50	\$34,247.51 - \$42,745.00	\$42,745.01 - \$51,500.00	≥\$51,500.01
5	\$0 - \$30,170.00	\$30,170.01 - \$40,126.10	\$40,126.11 - \$50,082.20	\$50,082.21 - \$60,340.00	≥\$60,340.01
6	\$0 - \$34,590.00	\$34,590.01 - \$46,004.70	\$46,004.71 - \$57,419.40	\$57,419.41 - \$69,180.00	≥\$69,180.01
7	\$0 - \$39,010.00	\$39,010.01 - \$51,883.30	\$51,883.31 - \$64,756.60	\$64,756.61 - \$78,020.00	≥\$78,020.01
8	\$0 - \$43,430.00	\$43,430.01 - \$57,761.90	\$57,761.91 - \$72,093.80	\$72,093.81 - \$86,860.00	≥\$86,860.01
9	\$0 - \$47,850.00	\$47,850.01 - \$63,640.50	\$63,640.51 - \$79,431.00	\$79,431.01 - \$95,700.00	≥\$95,700.01
10	\$0 - \$52,270.00	\$52,270.01 - \$69,519.10	\$69,519.11 - \$86,768.20	\$86,768.21 - \$104,540.00	≥\$104,540.01
% POVERTY	100%	125%	150%	175%	200%
PATIENT PAYS	\$15	\$25	\$35	\$45	100%

For Family Units with more than 10 members, for each additional member add \$4420.00.  
Based on 2019 Federal Poverty Level (FPL) Guidelines.

# HEALTHCARE THAT WORKS FOR YOU

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