Application for Patient Free Care/Discount Arrangements

Thank you for your interest in our Free Care Program. In order to assist you in a timely manner and avoid a denied application please read and follow the listed requirements below.

1. Please return a completed application. Applications must be signed and dated. Incomplete and unsigned applications will not be considered or processed.

2. Must provide proof of income.
    a. Recent Tax Return
    b. Bank Statement – 3 months
    c. Paystubs
    d. If no income please provide a signed letter of support

    Applications will be denied if you do not provide this information.

3. Please include letter of determination from Mainecare if you have recently applied.

Our office is happy to assist with your financial needs. Please contact us if you have any questions on the application process.

Sincerely,

J. Waite

Collections Representative
(207) 723-7247 or (207) 723-5161 ext 369

NOTICE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

In accordance with Chapter 150, Hospital Finance Rules, Section l, this hospital will provide Free Care to residents of Maine whose income fall below the following annual income guidelines:

FAMILY SIZE	100% DISCOUNT	50% DISCOUNT
1	$18,090	$24,120
2	$24,360	$32,480
3	$30,630	$40,840
4	$36,900	$49,200
5	$43,170	$57,560
6	$49,440	$65,920
7	$55,710	$74,280
8	$61,980	$82,640

Add $6,270 each additional person

You can apply for free care at the Financial Counselor's office or any of our Hospital Based Physician offices.

You will be asked if you have insurance of any kind to help pay for your care. You may also be asked to show that insurance or a government program will not pay for your care.

Only necessary medical care is given as free care.

If you do not qualify for free hospital care, you are allowed to ask for a fair hearing. We will tell you how to apply for a fair hearing.

The Hospital also offers a payment arrangement option based on your ability to pay. Please contact the Financial Counselor's office at Millinocket Regional Hospital.

02/07/2017

Application for Financial Assistance

Patient's Name:_____ Social Security #: _____.

Applicant Name: (if someone other than patient): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Please list all family members (including you). A family includes two or more people related by birth, marriage, or adoption who reside together and among whom there are legal responsibilities for support. Income includes wages, social security, unemployment, worker's compensation, interest income, child and/or spousal support, pensions, annuities, and public assistance, for example. Please provide proof of all income reported.

Name	Age	DOB	Relationship to Patient	Gross Income 3 months Prior to Date of Service	Gross Income 12 Months Prior to Date of Service	Source of Income or Employer

Note: If no income is reported for the above time periods, please mark:"None" as the income source and place $0.00 as the income. If you reported no income above, please provide a brief explanation below or on a separate piece of paper of how you or the patient provide for yourselves financially. If another person provides financial support, please provide a signed statement from that person stating they are providing support. _____

_____

Should a subsequent review of an individual's financial aid application find that the information provided by the individual was either incorrect or fraudulent, the decision to provide financial aid may be reversed and the responsible party will be billed. Financial Assistance is only applied to medically necessary inpatient and outpatient services.

CERTIFICATION: By signing this document, I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain benefits.

Application Signature: _____Date: _____