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	$19,140	$25,520
2	$25,860	$34,480
3	$32,580	$43,440
4	$39,300	$52,400
5	$46,020	$61,360
6	$52,740	$70,320
7	$59,460	$79,280
8	$66,180	$88,240

Add $6,720 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.

2/11/2020

Millinocket Regional Hospital
Application for Free Care/Discount Arrangements

NAME:	Date of Request:
ADDRESS:	
TELEPHONE:	BIRTH DATE:
OCCUPATION:	
EMPLOYER NAME & ADDRESS:	
SOCIAL SECURITY #:	
SPOUSE'S NAME:	
ADDRESS (IF DIFFERENT):	
TELEPHONE (IF DIFFERENT):	BIRTH DATE:
OCCUPATION:	
EMPLOYER NAME & ADDRESS:	
SOCIAL SECURITY #:	

DEPENDENTS:	
NAME:	BIRTH DATE:
NAME:	BIRTH DATE:
NAME:	BIRTH DATE:
NAME:	BIRTH DATE:

INCOME: List income for family from sources listed below and **ATTACH VERIFICATION** of all income. Do not include food stamps.

SOURCE	TOTAL FOR LAST 3 MONTHS	TOTAL FOR LAST 12 MONTHS
WAGE (attach pay stub copy)		
FARM OR SELF EMPLOYMENT (attach tax return copy)		
OTHER (attach copies)		
PUBLIC ASSISTANCE		
SOCIAL SECURITY		
UNEMPLOYMENT		
STRIKE BENEFITS		
ALIMONY/CHILD SUPPORT		
MILITARY FAMILY ALLOTMENTS		
PENSIONS		
INCOME FROM DIVIDENDS, INTEREST		
NET GAMBLING OR LOTTERY WINNINGS		
WORKER'S COMPENSATION		

Please list any and all current sources of coverage for your medical bills:

_____

_____

_____

ATTESTATION

I affirm that the above and attached information is true and correct to the best of my knowledge.
I also give permission for Millinocket Regional Hospital to investiage all facts pertaining to the above.
I also understand that if the information, which I submit is determined to be false, such a determination will result in a denail of providing services such as free care and that I will be liable for payment.

_____ _____

Signature Date