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. We can be reached at (207) 723-3369.

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	$22,590	$30,120
2	$30,660	$40,880
3	$38,730	$51,640
4	$46,800	$62,400
5	$54,870	$73,160
6	$62,940	$83,920
7	$71,010	$94,680
8	$79,080	$105,440

Add $5380 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.

02/01/2024

MILLINOCKET REGIONAL HOSPITAL

FREE CARE APPLICATION

APPLICANT

APPLICANT LAST	FIRST	MI	SSN	
DATE OF BIRTH	MARITAL STATUS		HOME PHONE	CELL
MAILING ADDRESS	CITY		STATE	ZIP
CURRENT EMPLOYERS NAME & PHONE #		POSITION		START DATE
PREVIOUS EMPLOYERS NAME & PHONE #		POSITION		END DATE

SPOUSE/CO-APPLICANT

APPLICANT LAST	FIRST	MI	SSN	
DATE OF BIRTH	MARITAL STATUS		HOME PHONE	CELL
MAILING ADDRESS	CITY		STATE	ZIP
CURRENT EMPLOYERS NAME & PHONE #		POSITION		START DATE
PREVIOUS EMPLOYERS NAME & PHONE #		POSITION		END DATE

HOUSEHOLD INFORMATION

If you share a household with another individual with whom you have a mutual child, you must apply together and provide income information for all of you.
If you are being claimed as a dependent on another individual's tax return, you must provide their current tax return and most recent pay stubs in addition to your own.

CHILDREN OR DEPENDENTS

LAST	FIRST	RELATIONSHIP	DOB	MONTHLY INCOME
				$
				$
				$
				$
				$

GROSS INCOME (BEFORE TAXES) PLEASE LIST ALL TAXABLE & NON TAXABLE INCOME

APPLICANT	PER YEAR	HOUSEHOLD "EARNINGS	PER YEAR
WEEKLY HOURS	$	WEEKLY HOURS	$
DIVIDENDS/INTEREST	$	DIVIDENDS/INTEREST	$
BUSINESS/SELF-EMPLOYMENT	$	BUSINESS/SELF EMPLOYMENT	$
SSI,SSDI,SSA	$	SSI,SSDI,SSA	$
WORKERS COMP	$	WORKERS COMP	$
MILITARY/PENSION	$	MILITARY/PENSION	$
UNEMPLOYMENT	$	UNEMPLOYMENT	$
TANF	$	TANF	$
ALIMONY/CHILD SUPPORT	$	ALIMONY/CHILD SUPPORT	$
OTHER	$	OTHER	$

CONTINUED ON BACK

ASSETS

***ASSETS OWNED WITH OTHERS (i.e.. BANK ACCOUNTS) *STOCKS/BONDS *ANNUITIES *TRUSTS**

NAME(S) ON ACCOUNT	TYPE OF ASSET (SEE ABOVE)	NAME OF BANK OR INSTITUTION	ACCOUNT NUMBER	CURRENT BALANCE OR VALUE
				$
				$
				$

LIST LIFE INSURANCE OWNED BY YOURSELF AND/OR YOUR SPOUSE (WHO LIVES WITH YOU):

OWNER	COMPANY NAME AND ADDRESS	FACE VALUE	CASH VALUE
		$	$
		$	$

DO YOU OR ANYONE IN YOUR HOUSEHOLD OWN ANY LAND, BUILDINGS, TIME SHARES OR JOINT REAL ESTATE?
YES ☐ NO ☐ IF YES, LIST BELOW:

OWNER	TYPE OF REAL ESTATE

DO YOU OR ANYONE IN YOUR HOUSEHOLD OWN ANY CARS, TRUCKS, BOATS, CAMPERS, MOTORCYCLES, SNOWMOBILES, ATV'S TRAILERS, TRACTORS, OR OTHER MOTORIZED VEHICLES? YES ☐ ☐

YEAR	MAKE	MODEL	OWNER	VALUE
				$
				$
				$

EXPNESES/LIABILITIES		MONTHLY PAYMENT	BALANCE DUE
RENT	LANDLORD'S NAME	$	$
HOUSE MORTGAGE	BANK	$	$
OTHER MORTGAGES	BANK	$	$
AUTO LOANS	BANK	$	$
LOANS	BANK	$	$
CHARGE ACCOUNTS	MC/VISA/OTHER	$	$
UTILITIES	ELECTRIC/WATER/OIL	$	$
OTHER BILLS	IF MORE SPACE NEEDED ATTACH	$	$
	SEPARATE PAPER	$	$

***ATTACH ANY COMMENTS TO EXPLAIN YOUR FINANCIAL CONDITION IN MORE DETAIL**

APPLICANT_____ **Co-Applicant**_____

I attest that I am a Maine Resident and the information I have provided is to the best of my knowledge, true and accurate.
I understand that Millinocket Regional Hospital or any of its agents has the right to verify any or all information provided.