

***Financial Clearance Department***

***PO Box 4100***

***Lewiston, ME 04243-4100***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Dear Patient,

Thank you for choosing Central Maine Healthcare as your health care provider. We are pleased to have served you.

The information gathered on this Free Care form will be used to help determine if you qualify for financial assistance.

**We will require that you apply for MaineCare, for all family members applying, prior to being considered for our free care program. Please contact your local Department of Health and Human Services (DHHS) office to apply.**

To process your application we **must** have the following information/documentation included with the completed application:

* Proof of income for the last 13 consecutive weeks for all adult applicants of the household (see application for sources of income considered)
* If any adult has had no income for the last 13 weeks or has not received income for any part of the last 13 weeks, they will need to complete the form called ‘Missing/No Income or Tax Filing Verification Form’
* Copy of current MaineCare decision letters
* Federal Tax return is required for all adult applicants (pages 1&2 only)
* If you are self-employed, we require a copy of the current year’s federal tax form and last quarter Profit and Loss statement (Schedule C)

Please return the completed form and required information/documentation to:

Financial Clearance Department

29 Lowell Square

PO Box 4100

Lewiston, ME 04240

Once we have reviewed your information, we will notify you in writing of our determination. If you have any questions, please feel free to call our office at (207) 777-8050.

Sincerely,

Financial Clearance Team

Enc.

 NOTICE

FREE MEDICAL CARE FOR THOSE UNABLE TO PAY

Central Maine HealthCare’s mission is to provide access to medically necessary health care to all patients, regardless of their ability to pay. Central Maine Medical Center, Bridgton Hospital and Rumford Hospital offers free care to Maine residents who are at or below the Maine Free Care income levels.

|  |  |  |
| --- | --- | --- |
| ***Size of family unit*** | ***\*MaineCare/Medicaid***  ***150% of FPL*** | ***\*CMMC, BH, RH Free Care***  ***200% of FPL*** |
| 1 | $21,870 | $29,160 |
| 2 | $29,580 | $39,440 |
| 3 | $37,290 | $49,720 |
| 4 | $45,000 | $60,000 |
| 5 | $52,710 | $70,280 |
| 6 | $60,420 | $80,560 |
| 7 | $68,130 | $90,840 |
| 8 | $75,840 | $101,120 |
| ***For each additional person, add  this amount*** | $7,710 | $10,280 |

*Last Updated February 10, 2023*

You can apply for free care at the Patient Financial Services office or call us at (207) 777-8050 for more information.

You will be asked if you have insurance of any kind to help pay for your care. You will 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. The following services are NOT considered medically necessary under the Free Care Program:**

* Cosmetic Procedures
* Bariatric Services
* Sterilization/Birth Control
* Fertility Services
* Exercise programs including phase III cardiac rehab
* Circumcision
* Child Birth Education
* Breast Pump Rental

If you do not qualify for free hospital care, you are allowed to ask for a fair hearing or appeal. The hospital policy is available for review.

**Central Maine Healthcare Free Care Application**

*For questions regarding this application, please contact our Financial Clearance Department at (207) 777-8050*

**Applicant Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name Last Name MI | | | DOB | Social Security Number |
| Mailing Address | | City/State/Zip | | Phone Number |
| Marital Status | Employer (list all for the last 13 weeks, include end date(s) if applicable: | | Medical Insurance | |

**Spouse Information (Non-Married Adults must apply separately)**

|  |  |  |
| --- | --- | --- |
| First Name Last Name MI | DOB | Social Security Number |
| Employer (list all for the last 13 weeks, include end date(s) if applicable: | Medical Insurance | |

**Dependents** (must have claimed as dependent on your current federal income tax return to be included on application)

|  |  |  |  |
| --- | --- | --- | --- |
| First Name Last Name MI | DOB | Relationship to Applicant | Claimed on Taxes? |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |

|  |  |
| --- | --- |
| **Application Status – Office Use Only** | |
| **Financial Counselor:** |  |
| **Reviewed by:** |  |
| **Manager:** |  |
| **Director:** |  |
| **VP of Revenue Cycle:** |  |
| **Approved: \_\_\_\_\_**  **Denied: \_\_\_\_\_** | **Date:** |

|  |  |  |
| --- | --- | --- |
| **Gross Income** (check off all that apply) | **Applicant** | **Spouse** |
| Employment (includes tips) |  |  |
| Dividends / Interest |  |  |
| Gross Rental Income |  |  |
| Business / Self-Employment |  |  |
| Social Security / Disability |  |  |
| Workers Compensation |  |  |
| Military / Pension |  |  |
| Unemployment Compensation |  |  |
| Alimony / Child Support |  |  |
| Other Income: |  |  |
| **ATTACH ALL INCOME DOCUMENTATION** | | |

|  |
| --- |
| **MaineCare/Medicaid Coverage:** You must apply for MaineCare/Medicaid – Please attach a copy of the determination letter and it must include all household members listed on this application. |

I/We certify that all the information given is true and complete. I/We give permission to Central Maine Healthcare to verify any facts pertaining to the provided information. Please attach any additional Documentation that explains your Financial Situation.

**Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sign Here**

|  |  |
| --- | --- |
| **This Section for Office Use Only – Do Not Complete** | |
| **Application Received:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_  **Income:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Family Size:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Eff. Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Exp. Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_**  **Alias:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



***Financial Clearance Department***

***PO Box 4100***

***Lewiston, ME 04243-4100***

**Missing/No Income or Tax Filing Verification Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the purpose of applying for the Maine Free Care Program, I/we,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Applicant Name)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Spouse Name)*

Certify that I/we have not received income for any or all of the last thirteen (13) weeks.

*Briefly explain how you have managed to pay for necessary living expenses such as: shelter, food and utilities:*

Check here if you have not filed a tax return for the previous year.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_