Financial Advocate Team
300 Main Street
Lewiston, ME 04240

Dear Patient,

Thank you for choosing Central Maine Healthcare. We are pleased to have served you.

The following information is required to determine if you qualify for our financial assistance program, Free Care, at a full or discounted rate.

All family members on the application must apply for MaineCare before being considered for our Free Care program. Contact your local Department of Health and Human Services (DHHS) office to apply. Our Financial Advocate team can assist you with this application if you prefer.

The following information/documentation must be included with the completed Free Care application:

- Proof of income for the last 13 consecutive weeks for all household adult applicants. Examples of proof of income include: employment and unemployment pay stubs, Social Security benefit letters, and pension benefit letters.
    - See page 3 for additional sources of income considered
- If any adult has had no income for *any or all* of the last 13 weeks, they need to complete the "Missing/No Income or Tax Filing Verification Form"
- A copy of the current MaineCare decision letters for all family members on the application
- A copy of the current Federal Income Tax Return is required for all adult applicants (pages 1&2 only)
- If you are self-employed, a copy of the current Federal Income Tax Return, including Schedule C, is required, and the previous quarter's Profit and Loss statement

Return the completed application and required information/documentation to:

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300 Main Street
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Once we have reviewed your information, we will notify you in writing of our determination. Please allow a minimum of 5 weeks for processing. If you have any questions, please call our office at (207) 786-1803.

Sincerely,

Financial Advocate Team

NOTICE

FREE MEDICAL CARE FOR THOSE UNABLE TO PAY

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

Size of family unit	***Maine Free Care***	***CMMC, BH, RH Free Care 100% Discount***	***CMMC, BH, RH Free Care 55% Discount***
1	$23,475	$31,300	$39,125
2	$31,725	$42,300	$52,875
3	$39,975	$53,300	$66,625
4	$48,225	$64,300	$80,375
5	$56,475	$75,300	$94,125
6	$64,725	$86,300	$107,875
7	$72,975	$97,300	$121,625
8	$81,225	$108,300	$135,375
For each additional person, add this amount	$8,250	$11,000	$13,750

Income Guidelines Last Updated January 20, 2025

To apply for Free Care, obtain more information, or schedule an appointment to meet with one of our financial advocates in person, call us at (207) 786-1803.

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 may request a fair hearing or appeal. The hospital policy is available for review.

Central Maine Healthcare Free Care Application

For questions regarding this application, contact our Financial Advocate at (207) 786-1803

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, including 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, including 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.					

Gross Income (check off all that apply)	**Applicant**	**Spouse**
Employment (includes tips)		
Dividends, Interest, rents, royalties, or periodic receipts from estates or trusts		
Gross Rental Income		
Business / Self-Employment		
Social Security / Disability		
Workers Compensation		
Military / Pension		
Unemployment Compensation		
Alimony / Child Support		
TANF / General Assistance		
Net gambling or lottery winnings		
Other Income:		
ATTACH ALL INCOME DOCUMENTATION		

Application Status – Office Use Only	
Financial Advocate:	
Reviewed by:	
Manager:	
Director:	
VP of Revenue Cycle:	
Approved: _____ **Denied: _____**	**Date:**

MaineCare/Medicaid Coverage: You must apply for MaineCare/Medicaid – Please attach a copy of the determination letter that includes 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.

Sign Here

Applicant Signature: _____Date:_____
Spouse Signature: _____ Date: _____

Application Received: ____/____/_____ **Income: _____Family Size: _____**	**Eff. Date: _____/_____/_____ Exp. Date_____/_____/_____** **Alias: _____**

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Missing/No Income or Tax Filing Verification Form

Date: _____

For the purpose of applying for Free Care assistance, I/we have not received income for any or all of the last thirteen (13) weeks.

_____
(Applicant Name)

_____
(Spouse Name)

REQUIRED: *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: _____

Applicant(s) not available to sign. Information supplied by:

Name: _____ Relationship: _____

Date: _____