MaineHealth

MaineHealth Financial Counseling

Request for Free Care or Extended Payment Plan

I am applying for: Free Care ❑ Extended Payment Plan ❑ Both ❑

Applicant Information

Name		DOB	SSN *(last four digits)* ___ ___ ___ ___
Address	City/State/Zip		Phone
Marital Status	Employer (list all for the last 3 months)		Start Date and Salary
Insurance (if none, indicate N/A)	Policy # (if applicable)		Effective Date (if applicable)

Spouse/Co-Applicant Information (Married or Registered Domestic Partners Only)

Name		DOB	SSN *(last four digits)* ___ ___ ___ ___
Phone #	Employer (list all for the last 3 months)		Start Date and Salary

In the case that applicant is married but separated from spouse, a copy of the legal separation or divorce filing is required.

Dependents (All Applicants Under 18 Years of Age and Currently Residing with Applicant)

Name	DOB	Relationship to Applicant	MaineCare ID #

Household Income for the last 3 months

Applicant and their household must provide previous year's complete federal tax return, or notarized statement claiming no income.

If Household Receives:	Amount per Month:	Applicant Must Provide:
Earnings/wages from employer(s)	$	Last 13 weeks or last 12 months of paystubs or pay detail report from each job showing gross income AND previous year's complete federal tax return
Self Employed/Rental income	$	Last 3 months or 12 months profit and loss statement AND previous year's complete federal tax return.
Unemployment, STD, LTD or workers' comp benefits	$	Weekly Claims report showing last 13 weeks or 12 months gross income OR pay detail from employer showing disability payment.
Social Security or SSDI	$	Current year benefit letter. To request a copy of your benefit letter, call 1-877-405-1448 or visit www.ssa.gov. 1099 Form not acceptable
Retirement or Pension Benefits	$	Benefit letter or statement (401K, IRA, etc.) showing gross amount distributed. 1099 Form not acceptable.
General Assistance	$	Current month General Assistance benefits letter.
No income for the last 3 months	$	Notarized statement explaining the support you are receiving, signed by the person providing the support. If living off savings, you will also need to provide 3 months of bank statements.
Alimony/Child Support	$	Copy of court order OR 3 months of cashed checks/receipts.
Dividends/Interest	$	Quarterly dividend statements OR 3 months' bank statements.
Other	$	Lottery winnings, non-wage earnings, cash for odd jobs, etc. for the last 3 months

Please turn to other side of form.

Other Document Requirements

In the case that any free care applicant is:

- Under 21 years of age or over 65.
- Blind or disabled (or condition preventing employment in past year).
- Currently pregnant or applying for dependents.

The applicant may be asked to apply for MaineCare at local Department of Health and Human Services.

To apply, please call **1-800-442-6003** or visit **https://www.maine.gov/benefits/account/login.html**

Note: If you have recently applied for Mainecare, please send a copy of the determination letter with this application form. Inpatient admissions require a MaineCare determination.

Extended Payment Plan

Monthly payment requested: $_____

To justify an extended payment plan, please include the following information related to household expenses

Please list all monthly expenses that apply to applicant's household:

Expense:	Monthly Payment:	Expense:	Monthly Payment:
Housing (mortgage/rent)	$	Personal/ Home Equity Loan	$
Property Taxes	$	Child Care	$
Homeowners/ Renter's Insurance	$	401K/403B	$
Utilities:	-	Auto Loan	$
Home/Cell Phone	$	Auto Insurance	$
Electricity	$	Gasoline for Vehicle	$
Water/Sewer	$	Food	$
Cable/Satellite	$	Pet Costs	$
Internet	$	Medical Bills	$
Gas/Oil (Heat)	$	Credit Cards	$

Send completed application form and documents to:	**MaineHealth Patient Financial Services** **Attn: Financial Counseling** 301 Route 1, Suite C Scarborough, ME 04074-9701	Fax: (207) 661-8042

Please remember to include a copy of your proof of income documents.

I affirm that the given information, including income, is true and correct to the best of my knowledge. I understand that the information which I submit concerning my annual income and family size is subject to verification by MaineHealth. I also understand that if any of the information which I submit is determined to be false, such determination will result in a denial of providing services as Free Care, and that I will be liable for charges for services provided.

Applicant Signature_____ _____ ***Co-Applicant Signature***_____ _____
Date ***(or Patient Representative)*** ***Date***

For questions regarding this application, please contact our Customer Service team at (207) 887-5100 or toll-free at (866) 804-2499.