REV 1.7

Mayo Regional Hospital
Hospital Administrative District #4
897 West Main Street
Dover-Foxcroft, ME 04426

FINANCIAL ASSITANCE PROGRAM INSTRUCTIONS

Thank you for choosing and trusting Mayo Regional Hospital and/or Mayo Practice Associates with your care. We are pleased to serve you and offer this Financial Assistance Program to all our qualifying patients. The information used on this application will be used to help determine if you qualify for Mayo Regional Hospital's Financial Assistance Program. A written determination of your eligibility for financial assistance will be made within 30 days of receipt of your **complete** application.

To qualify for our Financial Assistance Program you must meet the following conditions/requirements:

-Be a State of Maine resident
-The care received must be an emergency or medically necessary.
-Meet income requirements according to the 2019 Federal Poverty Guideline Table on page 2
-Depending on you and your household members' circumstances, you may be required to complete an application for MaineCare and provide a decision letter prior to your application being considered complete.

For the purposes of this application, your household includes only those listed on your current Federal Tax Return (if you file taxes). Individuals 18 or older, though, should apply separately, unless they are disabled, you are their caregiver, and they have remained in your household. If so, please note on application.

PLEASE COMPLETE TABLE BELOW TO DETERMINE WHAT HOUSEHOLD DOCUMENTATION IS NEEDED

PROOF OF IDENTITY AND RESIDENCY	√ BOX	YOU MUST PROVIDE COPIES OF:
Proof of Identification		Copy of current **Driver's License or State ID card**
Proof of Maine Residency		Copy of current **State of Maine Driver's License or Maine ID Card , or other proof of residency,** such as utility bill
PROOF OF INCOME - IF ANYONE IN HOUSEHOLD IS/HAS::	**√ BOX**	**PROVIDE COPIES OF ANY OF THE ITEMS BELOW THAT APPLY TO YOU AND YOUR HOUSEHOLD**
Filed Federal Income Tax Return		The most recent **Federal Tax form**(s) with all supporting schedules.
Self Employed		The most recent **Federal Tax form**(s) with **ALL** supporting schedules. Also, an **Income Statement** showing net earnings for the most recent 3 months.
Earning Wages from an Employer		Most recent consecutive stubs-each job-**Weekly=13 stubs-Bi-weekly=7 stubs**
Receiving Social Security Income		The current year's **benefit letter**. To request a copy: 877-405-1448.
Receiving Social Security Disability-SSDI or SSI		The current year's **benefit letter**. To request a copy: 877-405-1448.
Receiving Short/Long Term Disability Benefits		The most recent **3 months of statements** showing gross income for benefit.
Receiving TANF or General or Public Assistance		The most recent **3 months of statements/benefit letters**. For a copy: 855-797-4357
Receiving Unemployment Benefits		The most recent **3 months of statements/benefit letters**. For a copy:www.file4ui.com
Receiving Worker's Compensation Benefits		The most recent **3 months of statements/benefit letters**. For a copy: 800-400-6856
Receiving Veterans Benefits		The most recent **3 months of statements/benefit letters.**
Receiving Retirement Benefits (401K, IRA, etc.…)		The most recent **3 months of statements** showing amount paid out/withdrawn.
Receiving Pension/Annuity Benefits		The most recent **3 months of statements/benefit letters.**
Receiving Alimony/Child Support Benefits		The most recent **court documents with gross amount** that should be paid to you
ALL APPLICATIONS PLEASE INCLUDE:	**√ BOX**	**GENERAL INSTRUCTIONS**
Supporting documentation as above		• Please do not staple documents. • Please write clearly and provide clear copies, as originals may not be returned. • **If requested, include MaineCare decision letter** for household - see attached instructions • Incomplete applications will be returned and will delay processing.
Signature and dates of applicant & co-applicant		
If requested, MaineCare application and decision		
Copies of all health or medical insurance cards for household		

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FINANCIAL ASSISTANCE PROGRAM GUIDELINES

Mayo Regional Hospital is committed to treating all patients who need our care regardless of their health insurance or financial situation. In addition, we offer services to help you arrange for payment of your bill, including insurance billing, financial assistance, and payment plans. Our Financial Assistance Program (FAP) may qualify you for a reduced rate or free care for a period of 12 months. After the initial 12 month period, we will require a new application with all the required supporting documents. We will send you a reminder letter about a month prior to the expiration of the 12 month period of eligibility.

Mayo Regional Hospital provides free care only for emergency and medically necessary care; to those with a household income 175% or less of the Federal Poverty Guidelines (FPG). The 2019 FPG was published in The Federal Register effective January 18, 2019.

Mayo Regional Hospital also gives a reduced rate to those with a household income between 176% and 225% of the Federal Poverty Guideline.

Mayo Regional Hospital will send make a written approval, deferral or denial letter of your eligibility for free or reduced rate services within 30 days of receiving your application.

Collection Activities

If you do not submit an FAP application or pay your patient balance due within the timeframes defined in our Billing and Collections Policy, your account may be referred to a collection agency for further action. If that occurs, you will be provided with at least one written notice (notice of actions that may be taken) that informs you of possible collection actions and a date after which such actions would be taken. This deadline cannot be earlier than 120 days after the first billing statement is sent to you. The notice must be provided to you at least 30 days before the date specified in the notice.

2019 FEDERAL POVERTY GUIDELINE (FPG) TABLE

Household Size	2019 FPG	Up to 175% of FPG	176% to 225% of FPG
1	$12,490	$21,858	$28,103
2	$16,910	$29,593	$38,048
3	$21,330	$37,328	$47,993
4	$25,750	$45,063	$57,938
5	$30,170	$52,798	$67,883
6	$34,590	$60,533	$77,828
7	$39,010	$68,268	$87,773
8	$43,430	$76,003	$97,718
+/Person	$4,420	$7,735	$9,945
Discount	**100%**		**65%**

Please contact Carol Blethen, Patient Counselor, with any questions or to submit your application.

Carol Blethen, Patient Financial Counselor
Telephone: 207-564-1615
Fax: 207-564-1616
cblethen@mayohospital.com

FILE # _

REV 1.6

MAYO REGIONAL HOSPITAL

FINANCIAL ASSISTANCE PROGRAM APPLICATION

HOUSEHOLD IDENTIFICATION

IF YOU FILE TAXES, ONLY INCLUDE THOSE LISTED ON MOST RECENT FEDERAL TAXES

CHILDREN MUST BE 17 OR YOUNGER; 18/OLDER MUST APPLY SEPARATELY (UNLESS DISABLED & YOU ARE CAREGIVER)

1.) WHERE/WHOM DID YOU SPECIFICALLY RECEIVE YOUR FINANCIAL ASSISTANCE APPLICATION:

2.) ARE YOU A STATE OF MAINE RESIDENT? Y OR N IF YES, INCLUDE COPY OF STATE ID. **IF NO**, DON'T QUALIFY-ASSISTANCE

3.) DO YOU FILE FEDERAL TAXES? Y OR N IF YES, INCLUDE **COMPLETE** COPY OF MOST RECENT FEDERAL TAXES

4.) HOW MANY LIVING IN YOUR FINANCIAL HOUSEHOLD; INCLUDING SPOUSES & CHILDREN/DEPENDENTS **UNDER 18**?

PERSON	FULL NAME	DOB	CLAIMED ON TAXES?	RELATIONSHIP
APPLICANT			Y N	SELF
PARTNER			Y N	
DEPENDANT #1			Y N	
DEPENDANT #2			Y N	
DEPENDANT #3			Y N	
DEPENDANT #4			Y N	

CONTACT INFORMATION

MAILING ADDRESS	
CITY, STATE, ZIP	
PHONE	HOME: CELL:
E-MAIL	

HOUSEHOLD GROSS INCOME

GROSS INCOME = INCOME BEFORE ANY TAXES AND DEDUCTIONS

MUST HAVE PROOF FOR THE 3 MOST RECENT MONTHS OF ALL SOURCES OF INCOME FOR ENTIRE HOUSEHOLD

5.) EARNING WAGES FROM JOB(S)? Y OR N IF YES, INCLUDE MOST RECENT **CONSECUTIVE** PAYSTUBS:**WEEKLY=13/BI-WEEKLY=7**

6.) ARE YOU SELF EMPLOYED? Y OR N IF YES, INCLUDE MOST RECENT FEDERAL TAXES WITH **SUPPORTING SCHEDULES**

INCOME SOURCE	APPLICANT		PARTNER		OFFICE USE ONLY		
	LAST 1 MONTH	LAST 3 MONTHS	LAST 1 MONTH	LAST 3 MONTHS	APPLICANT	PARTNER	TOTAL
SELF EMPLOYMENT	$	$	$	$			
WAGES FROM JOB(S)	$	$	$	$			
SOCIAL SECURITY BENEFIT	$	$	$	$			
DISABILITY-SSDI OR SSI OR SHORT/LONG TERM	$	$	$	$			
TANF/GENERAL/PUBLIC ASSISTANCE	$	$	$	$			
UNEMPLOYMENT BENEFIT	$	$	$	$			
WORKER'S COMPENSATION	$	$	$	$			
VETERANS BENEFIT	$	$	$	$			
RETIREMENT WITHDRAWL	$	$	$	$			
PENSION/ANNUITY BENEFIT	$	$	$	$			
OTHER INCOME							
TOTAL	$	$	$	$			

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MAYO REGIONAL HOSPITAL

FINANCIAL ASSISTANCE PROGRAM APPLICATION

FINANCIAL SITUATION STATEMENT

7.) PLEASE PROVIDE US WITH ANY OTHER INFORMATION ABOUT YOUR LIVING SITUATION THAT YOU WOULD LIKE US TO CONSIDER.

EMPLOYMENT HISTORY (LAST 3 MONTHS)

DESCRIPTION	APPLICANT	PARTNER
PLEASE CIRCLE CURRENT EMPLOYMENT STATUS	EMPLOYED DISABLED RETIRED UNEMPLOYED STUDENT SEEKING JOB SELF-EMPLOYED HOMEMAKER	EMPLOYED DISABLED RETIRED UNEMPLOYED STUDENT SEEKING JOB SELF-EMPLOYED HOMEMAKER
EMPLOYER #1		
EMPLOYER & JOB TITLE		
RATE OF PAY		
AVERAGE HOURS/CHECK	REGULAR: OVERTIME:	REGULAR: OVERTIME:
AVERAGE GROSS $/CHECK	REGULAR: $ OVERTIME: $	REGULAR: $ OVERTIME: $
FREQUENCY OF PAYCHECK	WEEKLY BI-WEEKLY MONTHLY VARIES	WEEKLY BI-WEEKLY MONTHLY VARIES
START DATE & END DATE		
REASON FOR ENDING		
EMPLOYER #2		
EMPLOYER & JOB TITLE		
RATE OF PAY		
AVERAGE HOURS/CHECK	REGULAR: OVERTIME:	REGULAR: OVERTIME:
AVERAGE GROSS $/CHECK	REGULAR: $ OVERTIME: $	REGULAR: $ OVERTIME: $
FREQUENCY OF PAYCHECK	WEEKLY BI-WEEKLY MONTHLY VARIES	WEEKLY BI-WEEKLY MONTHLY VARIES
START DATE & END DATE		
REASON FOR ENDING		
UNEMPLOYED		
LAST DATE EMPLOYED		
ARE YOU RECEIVING UNEMPLOYMENT BENEFITS?	YES OR NO STARTED: ENDING:	YES OR NO STARTED: ENDING:
REASON FOR UNEMPLOYMENT		

DHHS-MAINECARE

YOU MAY BE ASKED TO COMPLETE AN APPLICATION FOR MAINECARE FOR YOUR **ENTIRE** HOUSEHOLD

IF SO, ATTACH COPY OF MOST RECENT MAINECARE DETERMINATION LETTER FOR **ENTIRE** HOUSEHOLD

PERSON	FIRST NAME	DATE YOU APPLIED	ELIGIBLE?	START DATE	ENDING DATE
APPLICANT			Y N PENDING		
PARTNER			Y N PENDING		
DEPENDENT #1			Y N PENDING		
DEPENDENT #2			Y N PENDING		
DEPENDENT #3			Y N PENDING		
DEPENDENT #4			Y N PENDING		

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FINANCIAL ASSISTANCE PROGRAM APPLICATION

MEDICAL

IF INSURED BY FEDERAL/STATE GOVERNMENT OR A PRIVATE INSURER, COMPLETE TABLE FOR ENTIRE

8.) DOES ANYONE IN HOUSEHOLD HAVE INSURANCE? Y OR N IF YES, INCLUDE COPY OF **ALL** INSURANCE CARDS

PERSON	FIRST NAME	MEDICAL INSURANCE PROVIDER	ACTIVE	START DATE	ENDING DATE
APPLICANT PRIMARY INSURANCE			Y N		
APPLICANT 2ND INSURANCE			Y N		
PARTNER PRIMARY INSURANCE			Y N		
PARTNER 2ND INSURANCE			Y N		
DEPENDANT #1			Y N		
DEPENDANT #2			Y N		
DEPENDANT #3			Y N		
DEPENDANT #4			Y N		

SIGNATURE(S) & CERTIFICATION

APPLICATION MUST BE MAILED/SUBMITTED SAME DAY AS SIGNED & DATED

BY SIGNING YOU ARE ATTESTING TO THE FOLLOWING STATEMENT

I CERTIFY THAT ALL OF THE INFORMATION GIVEN IS TRUE AND COMPLETE. I GIVE PERMISSION TO MAYO REGIONAL HOSPITAL TO VERIFY ANY FACTS PERTAINING TO THE PROVIDED INFORMATION. I ALSO UNDERSTAND THAT IF THE INFORMATION SUBMITTED IS DETERMINED TO BE FALSE, THIS APPLICATION WILL BE DENIED AND I WILL BE LIABLE FOR ALL SERVICES PROVIDED.

APPLICANT'S SIGNATURE

PARTNER'S SIGNATURE

APPLICANT'S PRINTED NAME

PARTNER'S PRINTED NAME

DATE

DATE

FOR OFFICE USE

RECEIVING APPLICATION

	INITIAL SUBMISSION	2ND SUBMISSION	3RD SUBMISSION
MODE/BY WHOM			
DATE			

APPROVAL

APPROVED BY/DATE		RETRO DATE		APPROVAL LETTER	
GROSS INCOME	$	EFECTIVE DATE		UPDATE MRH/MPB	
PERCENTAGE	%	ENDING DATE		MAKE ID CARD	

INCOMPLETE/DENIAL

	INCOMPLETE #1	INCOMPLETE #2	DENIAL
BY			
DATE			
REASON			
DEFERRAL ENDS			
LETTER			
UPDATE MRH & MPB			