Northern Light Health

Acadia Hospital
A.R. Gould Hospital
Blue Hill Hospital
CA Dean Hospital
Eastern Maine Medical Center
Inland Hospital
Maine Coast Hospital
Mayo Hospital
Mercy Hospital
Sebasticook Valley Hospital

Date(s) of Service or Account Number(s)*: _____
_____

Application for Financial Assistance

Office Use Only:
FC Initials _____

This form serves as your application for financial assistance at the above-listed hospitals. In order to manage your care more effectively, if this single application is approved you will be eligible for assistance at each of these Northern Light Health hospitals. Your completed application will be shared among these hospitals only as permitted or required by law.

PATIENT/APPLICANT		EMPLOYMENT INFORMATION	NOT EMPLOYED?
NAME:		EMPLOYER NAME:	LAST DATE WORKED:
SSN (*optional*):	DOB:	HIRE DATE:	PLEASE EXPLAIN:
CELL/HOME PHONE:		JOB TITLE:	
ADDRESS:		PHONE:	
		ADDRESS:	
MARITAL STATUS:			(Office Use) MR#:

SIGNIFICANT OTHER/CO-APPLICANT		EMPLOYMENT INFORMATION	NOT EMPLOYED?
NAME:		EMPLOYER NAME:	LAST DATE WORKED:
SSN (optional):	DOB:	HIRE DATE:	PLEASE EXPLAIN:
CELL/HOME PHONE:		JOB TITLE:	
ADDRESS:		PHONE:	
		ADDRESS:	
MARITAL STATUS:			(Office Use) MR#:

DEPENDENTS IN HOUSEHOLD	RELATIONSHIP	DATE OF BIRTH	√ IF LIVING IN HOUSE	√ IF CLAIMED ON TAXES	INSURANCE	(Office Use) MR#

Will you be claimed as a dependent on any person's taxes for this year? YES NO	If Yes, Taxpayer Name:	Relationship to Taxpayer:

*Accounts will only be eligible for this program if the date of the application for financial assistance is within 240 days of the date of the first statement on each account in question

GROSS HOUSEHOLD MONTHLY INCOME	APPLICANT	CO-APPLICANT		APPLICANT	CO-APPLICANT
WAGES & SALARIES			MILITARY / PENSION		
DIVIDENDS / INTEREST / RENTAL INC.			UNEMPLOYMENT BENEFITS		
SHORT/LONG TERM DISABILITY			ALIMONY / CHILD SUPPORT		
BUSINESS/SELF-EMPLOYMENT			TANF OR GENERAL ASSISTANCE		
SOCIAL SECURITY INCOME/RETIREMENT			STIPENDS (COACHING, PASTORS ETC)		
SOCIAL SECURITY DISABILITY (SSDI)			LETTER OF SUPPORT / AID FROM FAMILY OR FRIENDS		
WORKERS COMPENSATION			OTHER INCOME:		
			TOTAL:	**$**	**$**
SIGNATURES:					
PATIENT/APPLICANT DATE			CO-APPLICANT DATE		

Content collected on the lower portion of this application is not used as part of the Financial Assistance Application Process. It is used to determine eligibility for other sources of payment.

HOUSEHOLD ASSETS		MONTHLY EXPENSES/LIABILITIES	MONTHLY PAYMENTS	BALANCE DUE
CASH		RENT/MORTGAGE PAYMENT		
CHECKING ACCOUNT		OTHER MORTGAGE PAYMENT		
SAVINGS ACCOUNT		PERSONAL OR STUDENT LOANS		
LIFE INSURANCE VALUE		CHARGE ACCOUNTS		
ANNUITIES BALANCE		PRESCRIPTIONS, MEDICAL BILLS		
STOCKS & BONDS VALUE		UTILITIES, PHONE, CABLE		
PROPERTY–YEARS OWNED		GROCERIES		
VEHICLES (YEAR/MAKE)		OTHER EXPENSES:		
OTHER VEHICLES VALUE		**TOTAL:**	**$**	**$**
BUSINESS EQUIP VALUE		**INSURANCE INFORMATION**		
OTHER ASSETS:		HAS ANYONE IN THE HOUSEHOLD APPLIED FOR MAINECARE IN THE PAST 3 MONTHS? _____		
TOTAL:	$	IF YES: ATTACH COPY OF DETERMINATION LETTER		
		DOES ANYONE IN THE HOUSEHOLD HAVE INSURANCE? Y / N		
		IF YES: ATTACH COPY OF CARD(S)		
		IF YES: IS INSURANCE THRU THE MARKET PLACE? Y / N		
SIGNATURES:				
PATIENT/APPLICANT DATE		CO-APPLICANT DATE		

Financial Assistance is the last resort and liability settlements must be resolved prior to Financial Assistance consideration.

Northern Light Health

Financial Application Instructions and Worksheet

Thank you for requesting an application for Financial Assistance at Northern Light Health. There are a few things we must have before a determination can be made. Your application must be complete, with all members of your household included. **Proof of income** for all household members must also be provided. Patients will be assisted in applying for accessible insurance coverage/MaineCare and/or third-party opportunities. You must be a Maine resident to qualify; non-residents will be considered for emergent and urgent care only. **Complete the worksheet below to find out what we need from you.**

√ ALL THAT APPLY TO ALL MEMBERS OF YOUR HOUSEHOLD

IF ANYONE IS…	√ BOX	YOU MUST PROVIDE COPIES OF:
Earning Wages from an Employer before deductions		Most recent paystubs or pay detail report from each job showing last 13 weeks or last 12 months of gross income.
Rental Income		Last 13 weeks or last 12 months Profit and Loss statement.
Self Employed		Last 13 weeks or last 12 months Profit and Loss statement.
Unemployed Receiving Unemployment Benefits		Weekly Claims report showing last 13 weeks gross income. To request letter, call 1-800-593-7660 or go to: https://www.maine.gov/labor/unemployment
Alimony, Child Support, or Military Family allotments		Benefits or Award Letter or Last 13 weeks or last 12 months showing gross income/payments.
Receiving Workers Compensation Benefits		Workers Compensation benefits or award letter showing the last 13 weeks or last 12 months gross income.
Receiving Short/Long term Disability Benefits		Benefits or Award Letter showing the last 13 weeks gross income. (confirmation letter if pending disability)
Receiving Social Security or Disability Income (SSI/SSDI)		Current year award letter. You can request a copy of your benefit letter by calling 1-877-405-1448 (Bangor area) or 1-877-319-3076 (Portland area.)
Dividends, interest, royalties from estates or trusts		Last 13 weeks or last 12 months showing gross income/payments.
Has a checking or savings account		The last 13 weeks bank statements
Retired and receiving retirement benefits		Benefit letter or statement (if 401K, IRA, etc.…) showing last 13 weeks gross income.
Receiving TANF or General Assistance payments		Determination letter from the Department of Health and Human Services (DHHS).
Not working, but friends or family are assisting you		Provide a letter explaining the support you are receiving, signed by the person providing the support.
Student		If you are claimed as a dependent on someone's tax return, you may be asked to provide information regarding their level of support.

Please provide copies of income statements as noted above, originals will not be returned.

Northern Light Health

To be considered for Financial Assistance, patients will be assisted in applying for accessible insurance coverage/MaineCare and/or third-party opportunities.

* Contact your local Department of Health and Human Services (DHHS) at 1-800-442-6003 or visit *https://www1.maine.gov/benefits/account/login.html*

Note: If you have recently applied with DHHS, please notify us and forward along a copy of the determination letter once received.

**If DHHS denies you for over income, you may still be eligible under a deductible ('spenddown').*

- Your application must be signed and dated.
- If you have questions about the application process, please call the telephone number listed on your bill.
- If you fail to provide the requested information, your application will be delayed or denied.
- Application Mailing Addresses:

Northern Light Acadia Hospital
Cianchette Building, 43 Whiting Hill Rd, Brewer, ME 04412
1-866-750-5001 or 207-973-5000

Northern Light AR Gould Hospital
140 Academy St, Presque Isle, ME 04769
207-768-4099 or 207-768-4481

Northern Light Blue Hill Hospital
Cianchette Building, 43 Whiting Hill Rd, Brewer, ME 04412
1-866-750-5001 or 207-973-5000

Northern Light CA Dean Hospital
Cianchette Building, 43 Whiting Hill Rd, Brewer, ME 04412
1-866-750-5001 or 207-973-5000

Northern Light Eastern Maine Medical Center
Cianchette Building, 43 Whiting Hill Rd, Brewer, ME 04412
1-866-306-7633 or 207-973-5000

Northern Light Inland Hospital
200 Kennedy Memorial Drive, Waterville, ME 04901
207-861-3055

Northern Light Maine Coast Hospital
50 Union St, Ellsworth, ME 04605
207-664-5495

Northern Light Mayo Hospital
897 West Main Street, Dover-Foxcroft, ME 04426
207-564-1615 or 207-564-8401

Northern Light Mercy Hospital
144 State Street, Portland, ME 04101
1-888-399-6171 or 207-553-6209

Northern Light Sebasticook Valley Health
Dow Building, 447 N Main St, Pittsfield, ME 04967
1-800-557-8578 or 207-487-4020