***Financial Advocate Team***
***300 Main Street***
***Lewiston, ME 04240***

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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 at either a full or discounted rate.

**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, or we can assist you with this application if you prefer.**

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 is required, including unemployment and workers compensation. If any household member receives Social Security a current year benefit letter is required and/or a copy of any pensions received (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 Advocate Team
300 Main Street
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) 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 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* | **Maine Free Care* | **CMMC, BH, RH Free Care 100% Discount* | **CMMC, BH, RH Free Care 50% 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 |

*Last Updated January 20, 2025*

To apply for Free Care, obtain more information, or schedule an appointment to meet with one our financial advocates in person, you can 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 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 Advocate Department 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 | | |
| Gross Rental Income | | |
| Business / Self-Employment | | |
| Social Security / Disability | | |
| Workers Compensation | | |
| Military / Pension | | |
| Unemployment Compensation | | |
| Alimony / Child Support | | |
| Other Income: | | |
| **ATTACH ALL INCOME DOCUMENTATION** | | |

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

**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.

**Sign Here**

**Applicant Signature:** ____________________________________________**Date:**_______________

**Spouse Signature:** _____________________________________________ **Date:** _______________

**Application Received:** ____/____/_______

**Income:**_______________________ **Family Size:** _______________

**Eff. Date:** _____/_____/______ **Exp. Date**_____/_____/_______

**Alias:** ___________________

*Financial Advocate Team*
*300 Main Street*
*Lewiston, ME 04240*

**Central Maine Medical Center**
**300 Main St**
**Lewiston, ME 04240**

**Bridgton Hospital**
**10 Hospital Drive**
**Bridgton, ME 04009**

**Rumford Hospital**
**420 Franklin St**
**Rumford, ME 04276**

# 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: ______________________________