MaineHealth

MaineHealth Financial Counseling

Request for Financial Assistance or Extended Payment Plan

I am applying for: Financial Assistance ❑ Extended Payment Plan ❑ Both ❑

Applicant Information

First Name	Last 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)

First Name	Last Name	DOB	SSN *(last four digits)* ___ ___ ___ ___
Phone #	Employer		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

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 accepted**
Retirement or Pension Benefits	$	Benefit letter or statement (401K, IRA, etc.) showing gross amount distributed.
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

A MaineCare or NH Medicaid determination letter is required if the applicant falls within the below categories:

- Income lower than 138% of the Federal Poverty Level for Maine residents
- Income lower than 133% of the Federal Poverty Level for New Hampshire residents
- Under 21 years of age or over 65 for Maine residents, Under 19 years of age or over 65 for New Hampshire residents
- Blind or disabled (or condition preventing employment in past year).
- Currently pregnant or applying for dependents.

Maine residents may be asked to apply for MaineCare and referred to the MaineHealth Access to Care team to assist you with this process. You may also apply by calling **1-800-442-6003** or visit **https://www.maine.gov/benefits/accounts/login.html**

New Hampshire residents may be asked to apply for Medicaid at your local Department of Health and Human Services. You may also apply by calling **1-603-447-3841** or visit **https://nheasy.nh.gov**

Note: If you have recently applied for MaineCare or NH Medicaid, please send a copy of the determination letter with this application.

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:	Expense:	Monthly Payment:
Housing (mortgage/rent)	$	Gas/Oil (Heat)	$	Credit Cards	$
Property Taxes	$	Personal/ Home Equity Loan	$	Medical Bills	$
Homeowners/ Renter's Insurance	$	Child Care	$	**Additional Expenses:**	-
Utilities:	-	401K/403B (If deducted from pay check do not add)	$		$
Home/Cell Phone	$	Auto Loan	$		$
Electricity	$	Auto Insurance	$		$
Water/Sewer	$	Gasoline for Vehicle	$		$
Cable/Satellite	$	Food	$		$
Internet	$	Pet Costs	$		$

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 Financial Assistance, and that I will be liable for charges for services provided.

Applicant Signature_____ _____ ***Co-Applicant Signature***_____ _____

Date ***Date***

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