*For a lifetime of caring*

# MID COAST–PARKVIEW HEALTH

Patient Accounts
329 Maine Street, Suite C100
Brunswick, Maine 04011
(207) 373-6075
wwww.midcoasthealth.com

Dear Patient or Guarantor:

Mid Coast Hospital and Mid Coast Medical Group offers a Financial Assistance Program which allows patients who meet specific income guidelines uncompensated or discounted outpatient, medically necessary services for six (6) months. A determination of qualification for inpatient financial assistance is made with each admission.

**Along with the completed financial application, the following financial documents, pertaining to your income, must be provided. Incomplete applications will not be considered.**

- Most recent Federal Tax Forms, with all schedules; **OR**
- IRS Form 4506-T, which is proof of non-filing status that can be obtained from the IRS. You can call 800-829-1040 to get this.

**AND**

- 3 preceding months paystubs or unemployment benefits; **OR**
- Social security checks; **OR**
- If living on investments or savings, 3 preceding months bank or brokerage statements; **OR**
- If you have no income, a copy of your General Assistance Award Letter, copy of food/SNAP assistance, or letter of support from the person who helps with living expenses.

Our goal is to provide an answer to all applicants within 30 days of receipt of a completed application with supporting documents.

If you have any questions regarding the Financial Assistance process or application, please contact us at (207) 373-6077.

Mail all completed documents to:

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Mid Coast–Parkview Health
329 Maine Street, Suite C100
Brunswick,Maine 04011

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## Mid Coast Hospital / Mid Coast Medical Group Financial Assistance Application & Disclosure

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home/Cell Phone: _____ Social Security Number: _____

| | | |
|---|---|---|
| Was the patient a Maine resident at the time of service? | YES | NO |
| Was the patient involved in an alleged accident that led to the need for services? | YES | NO |
| Have you applied for or been denied Maine Medicaid (Mainecare) coverage? | YES | NO |
| Number of people in the patient's family/household? | | |

| | |
|---|---|
| Total Wages or Social Security Income of the Patient: | |
| Total Wages of Spouse, if applicable: | |
| Alimony/Child Support: | |
| Other income (rental property, disability, retirement, self-employment, etc.): | |
| **Total Monthly Household Income:** | |

**CERTIFICATION**

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified and I authorize them to contact third parties to verify the accuracy of the information provide in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance. Any financial assistance granted to me may be reversed, and I will be responsible for payment of the bill(s).

BY: _____ DATE: _____

| **OFFICE USE ONLY:** | |
|---|---|
| Date Application Received: | |
| Total Annual Household Income: | |
| % of Federal Poverty Level: | |
| Status: | APPROVED @ _____ % DENIED |
| Date Award Letter/Denial Sent: | |
| Directors Signature: | |