

Important!

How the Financial Assistance Program works

What is the Financial Assistance Program?

- Patients in our Financial Assistance Program (FAP) can get discounts for many services.
- Assistance is based on household income and size.
- Annual federal poverty guidelines set income ranges for this program.
- The Financial Assistance Program is NOT health insurance.

Which services are covered and which are not?

- **Only Cary Medical Center (CMC) services are covered.**
- Please call our Financial Counselors at (207) 498-1617 or email billinghelp@carymed.org if you have questions about covered services.
- CMC works with other healthcare providers, please ask them if they offer a financial assistance program or similar.

How do I apply and get started with the program?

- Ask staff at the front desk for an application or go to www.carymed.org to learn more. We also have Financial Counselors that can help you apply. Financial counselors are located at:
 - Location: 24 Sweden Street, Suite 101, Caribou, ME 04736
 - Phone: (207) 498-1617 or 800-858-2279 ext. 1617
 - Email: billinghelp@carymed.org
- Apply at or before the services are rendered when you are unable to pay. This may be when you are a new patient or when you face hard times, such as losing a job.
- When you apply, please provide all required supporting documentation, as applicable.



SLIDING FEE DISCOUNT PROGRAM APPLICATION

Please fill in all the spaces below. If you do not have an employer or insurance, write "none."

Date(s) of Service applying for: _____

Primary Applicant Name: _____ Date of Birth: _____

Marital Status: _____ Phone Number (Home or Cell): _____

Social Security Number: _____

Mailing Address: _____

Where you live, if different from mailing address: _____

Employer Name: _____ Tax Filer: Yes ☐ No ☐

Employer Address: _____

Job Title: _____ Work Phone: _____ Hire Date: _____

If not employed – last date worked: _____ Please explain: _____

If you have insurance, write the name here: _____

Co-Applicant Name: _____ Date of Birth: _____

Marital Status: _____ Phone Number (Home or Cell): _____

Social Security Number: _____

Mailing Address: _____

Where you live, if different from mailing address: _____

Employer Name: _____ Tax Filer: Yes ☐ No ☐

Employer Address: _____

Job Title: _____ Work Phone: _____ Hire Date: _____

If not employed – last date worked: _____ Please explain: _____

If you have insurance, write the name here: _____

Total Number of persons in your household: _____ Check if you are a Veteran: ☐ (Active or Retired)

How to Apply for the Program:

- **Household income:**
 - Household income is based on all income earned by members of the home. The chart on page 4 shows income sources and documents needed.
 - Income may include any item listed on the Income Worksheet on page 5.
- **All required forms and documents must be submitted with this application.** You may return forms:
 - in person to the front desk at the:
Business Office
24 Sweden Street
Caribou, ME 04736
 - fax forms to 207-498-2352
 - or mail to:
Cary Medical Center
PO Box 1040
Caribou, ME 04736
- This application only applies to the applicants listed and any dependents.

We're here to help!

Monday - Friday 8:00am-4:00pm

Call (207) 498-1617 with any questions.

Cary Medical Center Financial Counselors can help you with these forms.



FINANCIAL ASSISTANCE PROGRAM APPLICATION

Members of Household & Mainecare Worksheet

Please list names and birthdates for you and all members of your household.

- If you file taxes or you are claimed as a dependent, your household is you and anyone else listed on the tax return.
- If you do not file taxes and are not claimed as a dependent by anyone else, your household is you, your spouse, and your children that live with you.
- For divorced/separated/joint custody parental relationships - dependent children may only be listed on one program application.
- Financially co-dependent unmarried couples living together with mutual children will be counted as one household.
- All married couples will be counted as a household.

First and Last Name	Date of Birth	Relation to You Self, spouse, child, parent, etc.	Gross Income Before deductions	Income Source Job, Social Security, SSI, TANF, etc.
1.				
2.				
3.				
4.				
5.				
6.				

** Please list any additional household members on another sheet of paper.

MAINECARE STATUS **A Mainecare approval/denial letter is required with this application.

Have you applied for Medical Coverage through the Department of Health and Human Services?

YES _____ NO _____

If yes, what date did you apply? _____



FINANCIAL ASSISTANCE PROGRAM APPLICATION

Income Worksheet

Please provide a copy of your most recent tax return and any other income statements listed below.

IF ANYONE HAS....	✓	Amount paid/ How often	YOU MUST PROVIDE COPIES OF
Wages and Salaries from an employer			Three months of most recent paystubs OR most recent paystub with employee start date and year to date income amount listed.
Self-Employment or Rental Income			Last year's tax return and <i>all</i> supporting schedules. Last 3 months rental receipts to show gross rental income.
Capital Gains, Dividends, Interest			Most recent tax filing
Unemployment Benefits			Unemployment benefit letter or Weekly Claims report showing current gross income. To request a letter, call 1-800-593-7660
Workers' Compensation Benefits			Workers Compensation benefits award letter showing gross distribution.
Short/Long Term Disability Benefits			Most recent pay stubs showing gross income for disability benefits for the last three months.
Social Security or Disability Income (SSI/SSDI)			Current year award letter. You can request a copy of your benefit award letter by calling 866-837-2719.
Retirement benefits			Benefit letter or statement (if 401K, IRA, <u>etc.</u> ...) showing gross amount distributed.
(or pays) Alimony or Child Support			Record of payments received or copy of the court order. Record of payments paid (bank statement, copy of check, etc.)
TANF			Benefit determination letter
No Income			Statement of support

- I certify that all my answers are correct and complete as far as I know.
- I will tell Cary Medical Center about any changes in my health insurance or family income.
- I understand that if I give false information, I will be disqualified from the program.
- I understand that this program is NOT health insurance.

**** Applicant signature date is the effective date.**

Applicant Signature: _____ Effective Date: _____

Co-Applicant Signature _____ Date: _____



FINANCIAL ASSISTANCE PROGRAM APPLICATION

Statement of Support for Applicants with No Income

Applicant Name: _____ **Date of Birth:** _____

Please check the box below that applies to you.

Signature of family member, friend or other is required if:

- ☐ I do not have income to support myself and either live with someone or have someone who supports my daily living expenses.
- ☐ I do not have income to support myself and I am homeless or couch-surfing.
- ☐ I do not have income and I am assisted by an agency for housing, food or other daily needs.
- ☐ I do not have income and am supported by savings
- ☐ I do not have income and am supported solely by Financial Aide (FAFSA)
- ☐ I have income to support myself but do not file a Federal Tax Return. Profit & Loss Statement Required.

Signature of shelter or housing staff is required if:

- ☐ I do not have income to support myself and am living in a shelter or transitional housing.

Applicant Signature

Date

Signature of Family Member, Friend or Other

Relationship to you

Date

Signature of Shelter or Transitional Staff

Date



MEDICAL CARE FOR THOSE WHO MAY QUALIFY FOR FINANCIAL ASSISTANCE

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In accordance with Chapter 150, Section 1 Hospital Finance Rules, Cary Medical Center will provide **Free Care** to residents of the State of Maine whose income falls below the following guidelines:

Federal Guidelines	Family Size	Percentage of Poverty		
		0-190%	191-200%	201-210%
		100% write off	75% write off	50% write off
\$14,580	1	\$27,702	\$29,160	\$30,618
\$19,720	2	\$37,468	\$39,440	\$41,412
\$24,860	3	\$47,234	\$49,720	\$52,206
\$30,000	4	\$57,000	\$60,000	\$63,000
\$35,140	5	\$66,766	\$70,280	\$73,794
\$40,280	6	\$76,532	\$80,560	\$84,588
\$45,420	7	\$86,298	\$90,840	\$95,382
\$50,560	8	\$96,064	\$101,120	\$106,176

For family units larger than 8, add \$5,140 per year for each additional person

If you believe you qualify for Free Care, please contact:

Financial Counselors' Office, Phone: (207) 498-1617

(800) 858-2279 ext. 1617

Email address: billinghelp@carymed.org

Before providing financial assistance, the hospital will ask for information about your income and ask you to show verification that insurance or government medical assistance programs will not pay for your care.

Only services that are medically necessary are provided within our Financial Assistance Program.

Individuals can access our application on our website, www.carymedicalcenter.org, or by visiting our financial counselors' office:

24 Sweden Street, Suite 101
Caribou, ME 04736

If you disagree with the determination, you may ask for a fair hearing. We can explain how to apply for a fair hearing.

The above income guidelines are effective February 6, 2023.