PLEASE COMPLETE THIS SIDE ONLY

CHARITY CARE	**E**	**I**	**D**
SLIDING SCALE	**E**	**I**	**D**
MAINECARE APP			

Penobscot Valley Hospital

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE

Date of Request:______________________

I request that PENOBSCOT VALLEY HOSPITAL (PVH) make a determination of my eligibility for financial assistance for medical services received at PVH. I understand I may be required to show proof of applying for Maine Care (Medicaid). I understand that the information which I submit concerning my annual income and family size is subject to verification by PVH. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as charity care and that I will be liable for payment. **Elective Care & services/charges denied by insurance (including Self Administered Drugs) will be non covered by Financial Assistance.**

NAME: (FIRST) (MIDDLE) (LAST)	
ADDRESS: (NO. & STREET) (CITY) (STATE) (ZIP)	
TELEPHONE #:	SOCIAL SECURITY #:
OCCUPATION:	
EMPLOYER NAME/ADDRESS:	

INCOME: List **Household** income from sources listed below and **ATTACH VERIFICATION** of all income. (Do **not** include food stamps.)

SOURCE	TOTAL FOR LAST 3 MONTHS	TOTAL FOR LAST 12 MONTHS
Wages		
Farm or Self-employment		
Public Assistance		
Social Security (SSI)(SSDI)		
Unemployment Compensation		
Workers Compensation		
Strike Benefits		
Alimony and/or Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest		
Net Gambling or Lottery Winnings		

SIZE OF FAMILY (List names and relationship)	

FINANCIAL ASSISTANCE EXPIRES 6 MONTHS FROM APPROVAL DATE

I affirm that the above and attached information is true and correct to the best of my knowledge.

______________________ DATE

______________________ SIGNATURE OF PERSON MAKING REQUEST

FOR PVH USE ONLY **Penobscot Valley Hospital**

Applicant Name________________________ **DATE RECEIVED** ______________ **EXPIRATION DATE**__________

DETERMINATION OF ELIGIBILITY ***(for hospital use only)***	
1. INCOME a. Total income for last 3 mos. b. Total income for last 12 mos.	$__________________x 4 =$__________________ $__________________
2. SOURCE OF INCOME VERIFICATION:	
3. THE APPLICANT IS 3a. THE APPLICANT IS	[ ] Eligible [ ] Deferred [ ] Ineligible for Charity Care. [ ] Eligible [ ] Deferred [ ] Ineligible for sliding scale program ________% **will be written off once patient has met their responsibility.**
4. REASON FOR DENIAL OR DEFERMENT:	
5. DATE OF DETERMINATION OR ELIGIBILITY/DENIAL	

____**Signature of Person Making Determination**

Applicant was provided with a copy of determination on: ____________________________**Date**

NOTICE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY (FINANCIAL ASSISTANCE)

Please Note: Financial Assistance is not eligible for collection agency accounts.

Based on poverty income guidelines published 1/01/2023 from the Department of Human Services, this hospital is required to provide financial assistance for Residents of Maine whose income falls below the following guidelines. Effective date for Penobscot Valley Hospital is 1/01/2023.

Size of Family Unit	Income Guidelines
1	$ 21,870
2	$29,580
3	$37,290
4	$45,000
5	$52,710
6	$60,420
7	$68,130
8	$75,840

Add $7,710.00 for each member with families over 8 members.

If you believe you qualify for financial assistance, please complete the required application (available in the Patient Financial Services and Patient Registration Offices) and return to the Patient Financial Office. You may also qualify based on our sliding scale guidelines. To contact a Patient Financial Services Representative, Please call **207-794-7367.**

Before providing financial assistance, the hospital will ask for information about your income and to show that insurance or a government medical assistance program (**MAINE CARE**) will not pay for your care. If you do not qualify for Financial Assistance, you are entitled to ask for a fair hearing at the above telephone number.

Elective Services are not covered under the Financial Assistance policy.