Penobscot Valley Hospital

CHARITY CARE E I D
SLIDING SCALE E I D

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE OR SLIDING SCALE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

Please Note: Collection agency accounts are not eligible to apply for Financial Assistance.

Based on 150% of the Federal Poverty Level guidelines published 01/2024 from the Department of Health & Human Services, we provide financial assistance for residents of Maine whose income falls below the following guidelines. Effective date is 01/2024.

Size of Family Unit	Income Guidelines	Size of Family Unit	Income Guidelines
1	$22,590	5	$54,870
2	$30,660	6	$62,940
3	$38,730	7	$71,010
4	$46,800	8	$79,808

Add $8,070 for each member with families over 8 members.

We also have a sliding scale of 150%-225% of the poverty scale for additional discount options. To review your situation please contact a Patient Financial Services Representative, at **207-794-7367.** Before providing financial assistance, the hospital will ask for information about your income. Any form of insurance or government healthcare coverage (Medicare or MaineCare) will be reviewed however this is not a requirement for financial assistance. If you do not qualify for financial assistance, you are entitled to ask for a fair hearing by calling **207-794-7367.**

By completing this application, I request that PENOBSCOT VALLEY HOSPITAL make a determination of my eligibility for financial assistance for medical services received at PVH. I understand I may be asked to apply for MaineCare (Medicaid) if I should choose. 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 denial of financial assistance coverage and that I will be liable for payment.

NAME:_____
(FIRST) (MIDDLE) (LAST)

ADDRESS:_____
(NO. & STREET) (CITY) (STATE) (ZIP)

TELEPHONE #: SOCIAL SECURITY # (Optional):

OCCUPATION:

EMPLOYER NAME/ADDRESS:

PLEASE ATTACH VERIFICATION OF ALL INCOME FOR CURRENT YEAR.

(WAGES/EARNINGS, PUBLIC ASSISTANCE, SOCIAL SECURITY(SSI), SOCIAL SECURITY BENEFIT LETTER, UNEMPLOYMENT, WORKERS COMPENSATION, ALIMONY OR CHILD SUPPORT, PENSIONS, INCOME FROM DIVIDENDS, INTEREST, NET GAMBLING/LOTTERY)
You may be asked for copy of income taxes or your 1099 form. (**Do not include food stamps, tax refunds, or gifts**.)

SIZE OF FAMILY
(List names and relationship)

_____ _____ _____
_____ _____ _____

FINANCIAL ASSISTANCE/SLIDING SCALE EXPIRES 6 MONTHS FROM APPROVAL DATE

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

_____ _____
SIGNATURE OF PERSON MAKING REQUEST DATE

FINANCIAL ASSISTANCE (INCLUDING SLIDING SCALE) COVERS SERVICES THAT ARE MEDICALLY NECESSARY AS DEFINED BY MAINECARE. FINANCIAL ASSISTANCE APPLIES TO HOSPITAL AND RURAL HEALTH CENTER BILLS ONLY.

UPDATED 01/15/24.