



FINANCIAL ASSISTANCE APPLICATION

Medical care for those who cannot afford to pay

Effective January 2026 — Based on the 2026 Federal Poverty Level (FPL) guidelines from the U.S. Department of Health and Human Services, Penobscot Valley Hospital (PVH) offers financial assistance to Maine residents with incomes at or below 150% of the FPL and sliding scale assistance up to 225% of the FPL.

		<= % of FPL				
		150%	175%	200%	225%	
2026 Federal Poverty Level (FPL)*		FAMILY SIZE				
\$	15,960	1	\$23,940	\$27,930	\$31,920	\$35,910
\$	21,640	2	\$32,460	\$37,870	\$43,280	\$48,690
\$	27,320	3	\$40,980	\$47,810	\$54,640	\$61,470
\$	33,000	4	\$49,500	\$57,750	\$66,000	\$74,250
\$	38,680	5	\$58,020	\$67,690	\$77,360	\$87,030
\$	44,360	6	\$66,540	\$77,630	\$88,720	\$99,810
\$	50,040	7	\$75,060	\$87,570	\$100,080	\$112,590
\$	55,720	8	\$83,580	\$97,510	\$111,440	\$125,370
*add \$5,680 for each additional family member		Full assistance discount	100%			
		Sliding scale discount up to		50%	25%	15%

The following applies to all applications:

- Income details are required; insurance coverage will be considered but not required.
- If denied, you may request a fair hearing.
- Assistance is not available for accounts in collections.
- Applies only to medically necessary services as determined by MaineCare.
- Available for hospital and rural health center bills only.
- Assistance is valid for 6 months from approval.

Contact Patient Financial Services at 207-794-7367 to discuss your eligibility or ask any questions.

APPLICATION FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE AND SLIDING SCALE

NAME: _____			
(FIRST)	(MIDDLE)	(LAST)	
ADDRESS: _____			
(NO. & STREET)	(CITY)	(STATE)	(ZIP)
TELEPHONE #:	SOCIAL SECURITY # (Optional):		
OCCUPATION:	RESIDENT OF MAINE (YES/NO):		
EMPLOYER NAME/ADDRESS:			
Attach verification of current year income: Wages, SSI, Public Assistance, Social Security, Unemployment, Workers Comp, Alimony/Child Support, Pensions, Dividends/Interest, Net Gambling/Lottery. Do not include food stamps, tax refunds, or gifts. You may be asked for a copy of your tax return or 1099 form.			
SIZE OF FAMILY (List names and relationship)	_____	_____	_____
	_____	_____	_____

By signing below, I request Penobscot Valley Hospital to determine my eligibility for financial assistance for services received at PVH. I understand that the information I provide about my income and family size may be verified by the hospital. I may be informed about possible eligibility for MaineCare and asked to apply, but I am not required to do so to receive financial assistance. I also understand that if the information I provide is found to be false, my financial assistance may be denied, and I will be responsible for payment.

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

SIGNATURE OF PERSON MAKING REQUEST

DATE