Financial Assistance Program
APPLICATION
2015 – 2016

July 1, 2015 thru June 30, 2016

York Hospital Financial Assistance Office
15 Hospital Drive
York, Maine 03909

For Questions or Concerns please call

Last Name	A - K	207-351-2389
Last Name	L - Z	207-351-2398

Free Medical Care for Patients of York Hospital

In accordance with the guidelines put forth by the Maine Department of Health and Human Services, York Hospital is required to provide free care to residents of Maine whose incomes fall on or below 150% of the poverty level guidelines; York Hospital provides free care at 200% above the federal poverty guidelines, as outlined below.

Size of Family	Federal Income Guidelines	YH Income Guidelines
1	$11,770	$23,540
2	$15,930	$31,860
3	$20,090	$40,180
4	$24,250	$48,500
5	$28,410	$56,933
6	$32,570	$65,140

For family units with more than 6 members, add $ 8,120 for each additional member.

- You must have a billed service from York Hospital.
- Only York Hospital-owned Physician Practices and York Hospital Facilities are covered through the Financial Assistance Program. Please call if you have any questions on what is covered.
- All services must be considered medically necessary as determined by York Hospital to be part of the Financial Assistance Program.
- This Program does not cover prescriptions. Medications may be purchased through one of the York Hospital pharmacies if you do not have other prescription coverage.
- If you need help with medications please contact Pat Moher at 207-351-2652.
- YH Financial Assistance Program term runs annually from July 1st thru June 30th.

Living Well Center

Patients using the Financial Assistance Program benefit need to take note of the following changes for services at the Living Well Center. Visits beyond what is noted below will be subject to payment by the patient.

- Nutrition Therapy – one covered visit per year
- **Living Well General Exercise** - one month of classes per year will be covered
- **Cardiac Rehab Phase III** - one month of classes per year will be covered (Note, Cardiac Rehab Phase I & Phase II services are not affected by this change and will continue to be covered)
- **Pulmonary Rehab Phase III** - one month of classes per year will be covered (Note, Pulmonary Rehab Phase I & Phase II services are not affected by this change and will continue to be covered)

Wellness Services

Patients using the Financial Assistance Program benefit will be allowed a maximum of TWO (2) visits of any of the below services, covered at 100% at the York Hospital's Wellness First Program, within a 12 month period. Visits beyond the TWO allowed will be subject to payment by the patient.

- **Cranial Sacral Therapy**
- **Massage Therapy**
- **Reiki**

Non Covered Service

Cosmetic Plastic Services: Please note that cosmetic plastic surgery services will not be considered covered expenses for those on the Financial Assistance Program. All visits will be subject to payment by the patient.

Outside labs and Physicians not employed by York Hospital.

These changes will allow us the flexibility we need to continue to provide medical services to those in our community in need.

It is the patient's responsibility to inquire at the time of service what fees will/will not be covered.

YORK HOSPITAL FINANCIAL ASSISTANCE APPLICATION:

The York Hospital Financial Assistance Program runs yearly form July 1st to June 30th of the following year. You must notify York Hospital of any Insurance or State or Federal program that can be billed for the services you are requesting Financial Assistance for through this program.

Requirements:

Health Insurance Status: If you answer "yes" to any of the following questions, you will be asked to apply for Medicaid before being considered for our Financial Assistance Program.*

- Are there children under the age of 18 in the home? Y_____ N_____
- Are you pregnant? Y_____ N_____
- Are you disabled or unable to work for 12 months? Y_____ N_____

Maine's MaineCare (Medicaid) number is 1-800-482-0790 or 490-5418 or you may apply on-line at:
http://www.maine.gov/dhhs/OIAS/publice -assistance/index.html

Please submit the following proof **of income** for entire household:

PLEASE SEND **COPIES OF YOUR DOCUMENTATION-ORIGINALS WILL NOT BE RETURNED**

Required Documentation	Enclosed	Comments
2015 Federal Income Tax return		
2016 Proof of income: (entire household applying for FAP) Choose from the following:		
Current Pay Stubs showing a year-to-date total for 2016		
Profit and Loss Statement if self employed		
Copy of monthly social security check or pension check		
Copy of a bank statement showing direct deposit of social security or pension benefits		
Copy of current social security benefit statement		
Copies of workers compensation benefits		
Copy of unemployment check or benefit statement		
Copies of child support payments received		
Letter from employer		
Documentation with date Medicaid application was sent		

Your application **WILL NOT** be processed **until all requested information is received**. Statements will continue to be mailed to you as this is still patient responsibility until you receive your acceptance letter.

We will be reviewing financial documentation throughout the approval period.
You will be **notified in writing** of the determination of your application within four weeks.

(please see reverse side…)

Request for Determination of Eligibility for **F**inancial **A**ssistance **P**rogram

Application July 1, 2015 through June 30, 2016

As provided in the guidelines of the Department of Human Services, I hereby request that York Hospital make a written determination of my eligibility for Financial Assistance at YORK HOSPITAL. I understand that the information which I submit concerning my family's annual income and size are subject to verification by YORK HOSPITAL. 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 Financial Assistance, and that I will be liable for charges of services provided.

Last Name **First Name** Middle Initial Date of Birth

Physical Address City State Zip Code Social Security Number

Mailing Address (If different from physical) City State Zip Code length of time at address

Home Phone Number Work Phone Number

Medicaid Coverage

Have you applied for your State Medicaid?

____Yes ____No (Check One)

_____State of Residency

Private Insurance Company Name: _____ Private Insurance ID: _____

State Medicaid Number: _____ Medicare Number: _____

Please indicate ALL people living in the household applying for financial assistance including the applicant: Use additional sheet of paper if needed

	Name	Relationship to Applicant	Date of Birth	Social Security #
1				
2				
3				
4				
5				
6				

I affirm the above to be true and correct

Applicant's Signature: _____ Date: _____

The York Hospital Financial Assistance Program runs yearly from July 1, 2015 through June 30, 2016.

Please return the application to:
York Hospital – Financial Assistance
15 Hospital Drive, York, Maine 03909

Last Name A-K 207 351 2389
Last Name L-Z 207 351 2398