PVH Free Care/Sliding Scale Application

FREE CARE ____ E ____ I ____ D ______
SLIDING SCALE ___E ____ I ____ D ______

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR FREE CARE / SLIDING SCALE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY (FREE CARE)
Please Note: Collection agency accounts are not eligible to apply for Free Care.

Based on poverty income guidelines published 02/2015 from the Department of Health & Human Services, this hospital is required to provide free care for Residents of Maine whose income falls below the following guidelines. Effective date for PVH is 02/2015.

Size of Family Unit	Income Guidelines	Size of Family Unit	Income Guidelines
1	$17,655.	5	$42,615.
2	$23,895.	6	$48,855.
3	$30,135.	7	$55,095.
4	$36,375.	8	$61,335.

Add $6,240.00 for each member with families over 8 members

You may qualify for our sliding scale program based on sliding scale guidelines. To contact a Patient Financial Services Representative, call **207-794-7367.** Before providing free care, the hospital will ask for information about your income and to show that insurance or a government medical assistance program (**MaineCare**) will not pay for your care. 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 free care for medical services received at PVH. I understand I may be required to show proof of application for MaineCare (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 denial of free care coverage and that I will be liable for payment.

NAME:____
(FIRST) (MIDDLE) (LAST)

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

TELEPHONE #: SOCIAL SECURITY #:

OCCUPATION:

EMPLOYER NAME/ADDRESS:

PLEASE ATTACH VERIFICATION OF ALL INCOME FOR CURRENT YEAR.

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

SIZE OF FAMILY
(List names and relationship) ______ ______ ______
______ ______ ______

FREE CARE/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 ______________

SERVICES WHICH ARE NOT MEDICALLY NECESSARY ARE NOT COVERED UNDER FREE CARE OR THE SLIDING SCALE. FREE CARE IS FOR HOSPITAL BILLS ONLY.