MaineGeneral Community Care

Confidential Application for Fee Assistance

Program/Service Area/Counselor:_____

Name:_____DOB:_____
Person to call if other than patient_____ Relationship_____
Phone Number _____
Have you applied for MaineCare? ___ yes ___ no

Please list all family members, living with you (including self) (continue on back if needed)
Family members are individuals by birth, marriage, or adoption who reside together and for whom there are legal responsibilities for support.

Name	Relationship	Age	Employer	Gross Salary Weekly/biweekly/monthly

LIST ALL FAMILY INCOME OR BENEFITS BELOW

AFDC $_____ Food Stamps $_____
Social Security $_____ Bank Account $_____
Pension $_____ Unemployment $_____
Other $_____ (alimony/child support/interest income/rental income/etc.)

Total Family income for:

Three Months $_____ Twelve Months $_____

The information that I have provided is to the best of my knowledge is true and accurate. I understand that HealthReach has the right to verify any or all of this information.

_____ _____
Signature of Patient or Responsible Party Date

For office use:

Denied Date denied _____

Approved Date approved _____

HomeCare/Hospice % approved _____

Per Visit Payment from client for OPC Individual _____ Group _____

Reimbursement _____ Date _____

Director of Revenue Cycle _____Date _____

The 2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family	**Poverty guideline**
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430
For families with more than 8 persons, add $4,420 for each additional person.	

Rev. 1/19/2009
Rev 1/26/2009
Rev 10/01/2019