24 Hospital Lane, Calais, ME 04619

Financial Assistance Application Form Instructions

Thank you for requesting an application for Financial Assistance. There are a few things we must have before a determination can be made. **You must be a Maine resident to apply for financial assistance.**

We must have proof of all sources of income as follows:

- **Household Income:** All members of the household must be included on the application along with their proof of income. ***(Note: If anyone else can claim you as a dependent, that person must be included on the application along with their proof of income.)***
- **If you are actively employed or self-employed,** please attach **BOTH** of the following types of documentation to your application:
  - Confirmation of income earned in the **last 3 months,** such as paystubs.
  - Confirmation of your **annual income;** your 2020 tax return AND copies of your W-2's and 1099's as applicable
- **If you are receiving social security;** pensions or other forms of retirement income we must have a copy of the check received or a bank statement showing the deposits made. We will also accept a copy of your yearly benefit statement from the Social Security Administration.
- **If you are living on savings accounts or investments,** we need two consecutive months' statements to show that you are spending those funds to meet daily expenses.
- **If you are unemployed** and not receiving any income, we need a letter of support written by the person supplying your day-to-day needs.
- **If you are receiving unemployment benefits** we must have a copy of the check or determination letter.

The hospital reserves the right to an independent verification of income. It will be necessary for you to complete and sign form 4506T-EZ Short form request for Individual Tax Return Transcript (attached).

It will be necessary for you to apply for Mainecare due to the expanded Mainecare program for service rendered after 1-1-2019.

If you have already applied for Mainecare, please include a copy of their determination letter.

If you fail to provide the requested information your application will be deferred for 60 days. If you do not respond in 60 days your application will be denied. Please make sure you sign and date the application.

If you need assistance in completing the form, please feel free to call us.

207-454-9211 Tammy Mitchell, Patient Financial Services Director

Please mail to Attn: Free Care, CCH, 24 Hospital Drive, Calais, ME 04619

Calais Community Hospital Financial Assistance Application

Applicant(s) Name(s):				
Last	*First*	*MI*	*DOB*	*Social Security Number*
1.				
2.				

Address	City	State	Zip

Please list additional members in household:	Relationship	Date of Birth:	Claimed on Taxes?

GROSS INCOME	Household	Other
Weekly Salary		
Dividends/Interest		
Gross Rental Income		
Self-Employment		
Social Security/Disability		
Workers Compensation		
Unemployment		
Alimony/Child Support		
Other Income		
ATTACH DOCUMENTATION FOR ALL ENTRIES ABOVE	TOTAL $	TOTAL $

ASSETS	
Checking/Savings	
Real Estate	
Automobiles	
Life Insurance	
Other Vehicles, etc.	

MAINECARE COVERAGE

Have you applied for Mainecare?
______Yes ______No (Check one)
If you answered "Yes" to any of the questions on page 1, you will need to provide us with a formal denial letter from Mainecare.

I/We certify that all the information given is true and complete. I/We give permission Calais Community Hospital to verify any facts pertaining to the provided information. PLEASE ATTACH ANY ADDITIONAL DOCUMENTATION THAT EXPLAINS YOUR FINANCIAL SITUATION.

➔➔ Please sign here: Date:

THIS SECTION FOR OFFICE USE ONLY – DO NOT COMPLETE

Process Date: ____________________

Total Annual Gross Income: _______________________ Number of Dependents: ______________

APPROVAL _______	DEFERRAL _______	DENIAL _______
150% _____ 151 - 200% _____	Mainecare Denial _____	Over Income _____
Other comments	Proof of Income _____	Other ___________________

Coverage Period:______________________ Next Application Date:___________________

Processor Signature:____

VP of Finance Signature:____

FINANCIAL ASSISTANCE FOR THOSE UNABLE TO PAY

Calais Community Hospital (CCH) is committed to treating all patients who need our care regardless of their health insurance or financial status. In addition, we offer services to help you arrange for payment of your bill, from insurance billing, to payment plans, and even financial assistance, which may qualify you to have all or part of your bill written off.

CCH gives financial assistance to Maine people with family income at 150% or less of the Federal Poverty Income Guidelines as Free Care and those at 151-200% of the Federal Poverty Level as Reduced Care, which will provide a 75% reduction of the balance of your account.

Size of family unit & income guidelines:

	150% 100% discount	151-200% 75% discount
1	$19,320.00	$25,760.00
2	$26,130.00	$34,840.00
3	$32,940.00	$43,920.00
4	$39,750.00	$53,000.00
5	$46,560.00	$62,080.00
6	$53,370.00	$71,160.00
7	$60,180.00	$80,240.00
8	$66,990.00	$89,320.00

Add $6,810.00/$9,080.00 for each family member

To apply for Financial Assistance, contact the CCH Patient Financial Services Office at 207-454-9211 or online at www.calaishospital.org.

You will be asked if you have insurance of any kind to help pay for your care. You may also be asked to show that insurance or a government program will not pay for your care.

Only necessary medical care is covered under our financial assistance program.
If you do not qualify for financial assistance, you are entitled to ask for a fair hearing.
We will tell you how to apply for a fair hearing.

Form **4506T-EZ**
(July 2017)
Department of the Treasury
Internal Revenue Service

Short Form Request for Individual Tax Return Transcript

▶ **Request may not be processed if the form is incomplete or illegible.**
▶ **For more information about Form 4506T-EZ, visit *www.irs.gov/form4506tez*.**

OMB No. 1545-2154

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number or individual taxpayer identification number on tax return

2a If a joint return, enter spouse's name shown on tax return.

2b Second social security number or individual taxpayer identification number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Third party name | Telephone number

Address (including apt., room, or suite no.), city, state, and ZIP code

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in line 6 before signing. Sign and date the form once you have filled in this line. Completing this step helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Year(s) requested.** Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

Note. *If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS will notify you or the third party that it was unable to locate a return, or that a return was not filed, whichever is applicable.*

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** spouse must sign. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) | Date

▶ **Spouse's signature** | Date

Calais Community Hospital (CCH) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. CCH does not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

Calais Community Hospital

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the hospital at 207-454-7521.

If you believe that Calais Community Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Karen Theriault at 207-255-0272, email ktheriault@dech.org or fax to 207-255-0214. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Karen Theriault is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English Translation: You have the right to an interpreter at no cost to you. Please point to your language

Arabic — **العَرَبِيَّة**

من حقك الوصول إلى مترجم بدون تكلفة عليك، من فضلك اختر لغتك.

German — **Deutsch**

Sie haben das Recht einen Dolmetscher zu beanspruchen. Dieser Service ist kostenlos. Bitte geben Sie Ihre Sprache an und ein Dolmetscher wird gerufen.

Russian — **русский**

Вы имеете право на бесплатные услуги переводчика. Пожалуйста просим Вас указать на Ваш язык.

Chinese Cantonese — 漢語廣東話

您有權利獲得一位免費的口譯人員。請指出您的語言。

Japanese — **日本語**

無料で通訳サービスをご利用できます。ご自分の言語を選択してください。

Somali — **Af Soomaali**

Waxaad xaq u leedahay inaad heshid tujumaan aan lacag kuugu fadhin. Fadlan tilmaan luqaddaada.

Chinese Mandarin — 汉语普通话

您有权利获得一位免费的口译人员。请指出您的语言。

Khmer/Cambodian — ភាសាខ្មែរ

អ្នកមានសិទ្ធិទទួលបានសេវាអ្នកបកប្រែដោយឥតគិតកម្រៃ។ សូមចង្អុលទៅភាសារបស់អ្នក។

Spanish — **Español**

Usted tiene derecho a un intérprete sin costo alguno. Por favor, señale su idioma.

Dinka — Thuɔŋjäŋ

Yïn anong yïc bä näng dugëër kuä cïn kë täu pïny. Käpïëth Ku bä thuongdu nyuöth.

Korean — 한국어

귀하는 무료로 통역 서비스를 받으실 수 있습니다. 귀하의 언어를 선택해 주십시오.

Tagalog (Filipino) — **Tagalog**

May karapatan kang kumuha ng isang tagasalin nang wala kang babayaran. Mangyari lamang na ituro ang iyong wika.

Farsi — **فارسی**

شما از این حق برخوردار هستید که بدون هزینه از خدمات مترجم شفاهی بهره مند شوید. لطفاً به زبان مورد نظر خود اشاره کنید.

Oromo — **Oromiffa**

Tajaajila turjumaanaa kanfaltii irraa bilisa ta'e argachuu ni dandeessu. Maaloo, afaan barbaaddan caqasaa.

Thai — **ภาษาไทย**

คุณมีสิทธิ์ที่จะใช้ล่ามโดยไม่เสียค่าใช้จ่าย โปรดชี้ไปที่ภาษาของคุณ

French — **français**

Vous avez droit aux services gratuits d'un interprète. Veuillez préciser la langue que vous parlez.

Polish — **polski**

Masz prawo na nieodpłatnego tłumacza. Proszę wskazać język, w którym rozmawiasz.

Vietnamese — **Tiếng Việt**

Quý vị có quyền yêu cầu dịch vụ phiên dịch hoàn toàn miễn phí. Vui lòng cho biết ngôn ngữ của quý vị.