2025 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	$15,060	$30,120
2	$20,440	$40,880
3	$25,820	$51,640
4	$31,200	$62,400
5	$36,580	$73,160
6	$41,960	$83,920

For family units with more than 6 members, add $5,380.00 for each additional member.

ELIGIBILITY:

- You must have a patient statement/bill issued by York Hospital.
- **You must apply for Medicaid (MaineCare) from the state you reside in**. (See Document Requirements* on application). Proof can be the denial or acceptance letter. Letter must be dated within 1 year of application for financial assistance.
- All services must be considered medically necessary as determined by York Hospital to be a part of the Financial Assistance Program
- Only York Hospital-owned Physician Practices and York Hospital Facilities are covered through the Financial Assistance Program
- This program does not cover ambulance services, massage therapy, cranial sacral therapy, reiki, cosmetic/plastic surgery, dental services, out-side laboratory services, podiatry services, durable medical equipment, and any physician not employed by York Hospital
- Patient must prove financial eligibility for all dates of service that are to be considered through a Financial Assistance Program Application and requested income documentation.
- When application is approved outstanding balances will be covered back dated 240 days from the date of the application and through 12/31/2025.
- This program does not cover prescriptions. For assistance with medications, please call 207-351-2652.
- **PLEASE REMEMBER TO SIGN AND DATE YOUR APPLICATION**

*If required documents are not available, please contact the Financial Assistance Office

*APPLICATIONS WILL NOT BE PROCESSED UNTIL ALL REQUIRED DOCUMENTS ARE RECEIVED

FAP APPLICATION

January 1, 2025 to December 31, 2025

York Hospital
Caring for All

Applicant Information (Please print)

Last Name First Name Middle Name DOB			SSN
Address		City/State/Zip	Phone
Mailing Address		City/State/Zip	Marital Status
Email address		Current Employer	Start Date

Spouse/Co-Applicant Information (Married or Registered Domestic Partners Only)

Last Name First Name Middle Name DOB			SSN
Phone#		Employer	Start Date and Salary (yearly)

Dependents (All Applicants Under 18 Years of Age and Currently Residing with Applicant)

Name	DOB	Relationship	Insurance	Applying for FAP

Insurance (if none, indicate N/A)	Policy#	Effective Date
Is Insurance though the Marketplace/Affordable Care Act?		

Document Requirement *

A Medicaid determination letter is required unless the applicant has insurance through the Marketplace/Affordable Care Act.

A Maine resident is asked to apply for MaineCare and referred to our York Hospital Patient Navigator (207) 351-2007 to assist you with this process. You may also apply by calling 1-800-442-6003 or visit https://mainecahc.org/consumer-assistance/need-health-coverage/

New Hampshire residents may apply for Medicaid at your local Department of Health and Human Services. You may also apply by calling **1-603-447-3841** or visit https://nheasy.nh.gov.

Savings and Investments

Checking account balance	
Savings account balance	
Investment balance(s)	
IRA/403B/401K balance	
Automobile year/make/model	
Recreational vehicle year/make/model	

For questions regarding this application, please contact us at (207} 351-2309 or (207)351-2321.

Mail to: York Hospital, Attention Financial Assistance Office, 15 Hospital Drive, York, Maine 03909

Household Income

*Applicant and household must provide **2024** completed federal tax return, W-2, or other documents showing **2024** income.*
Applicant and household must provide **2025** income, furnish the below documentation:

If Household Receives:	Amount per Month:	Applicant Must Provide:
Earnings/wages from employer(s)	$	Year to date paystubs or pay detail report from each job showing gross income.
Self Employed	$	Year to date profit and loss statement.
Rental Income	$	Year to date statement of income
Unemployment, STD, LTD or workers' comp benefits	$	Weekly claims report showing year to date gross income OR pay detail from employer showing disability payment.
Social Security or SSD	$	**2023** and **2024** benefit letters. To request a copy of your benefit letter, call 1-877-405-1448 or visit www.ssa.gov. **1099 Form not accepted**
Retirement or Pension Benefits	$	Benefit letter or statement (401K, IRA, etc.) showing gross amount distributed.
General Assistance	$	Current month General Assistance benefits letter.
No income for the last 3 months	$	Request Self-Declaration letter from FAP office.
Alimony/Child Support	$	Copy of court order, 12 months of cashed checks/receipts, or bank statement.
Dividends/Interest	$	Quarterly dividend statements or 12 months bank statements.
Other	$	Lottery winnings, non-wage earnings, cash for odd jobs, etc. for the last 12 months

Please list all monthly expenses that apply to applicant's household:

Expense:	Monthly Payment:	Expense:	Monthly Payment:	Expense:	Monthly Payment:
Housing (mortgage/rent)	$	Cable/Internet	$	Credit Cards	$
Property Taxes	$	Childcare	$	Medical Bills	$
Homeowners/ Renter's Insurance	$	Personal/ Home Equity Loan	$	Pet Costs	$
Gas/Oil (Heat)	$	401K/403B	$	Internet	$
Home/Cell Phone	$	Auto Loan	$	Food	$
Electricity	$	Auto Insurance	$	Additional expenses	$
Water/Sewer	$	Gasoline for Auto	$		

Please remember to include a copy of your proof of income documents.

I affirm that the given information, including income, is true and correct to the best of my knowledge. I understand that the information which I submit concerning my annual income and family size is subject to verification. I also understand that if any of the information which I submit is determined to be false, such determination will result in a denial of providing services as Financial Assistance, and that I will be liable for charges for services provided.

*Applicant Signature*_____ *Co-Applicant Signature*_____

Date *Date*