Following this explanation is the application for the Northern Maine Medical Center's Financial Aid Program. This program covers emergent and medically necessary services only, it does not cover elective services.

Before processing your request for the NMMC Financial Aid Program, the following information is needed to establish eligibility:

1. Completed and signed application

2. Please provide the following documentation with your application:

    A. Copies of previous year's income tax return, along with copies of your W-2s
    B. Copies of pay stubs from the last three months
    C. If you are on Social Security or Disability, please include a copy of your award letter(s) or copy of bank statement showing direct deposit(s)
    D. Net receipts from nonfarm or farm self-employment (after deductions and expenses).
    E. Other proof of income for the last three months, including: Railroad retirement payments, strike/union funds, veteran benefits, TANF and general assistance payments, training stipends, alimony, child support, military family allotments, pensions, annuity payments, dividends, interests, rents, royalties, estates and trust payments, and net gambling or lottery winnings.

3. Return completed application and documents to the Patient Financial Advocate:
    a. In Person/Mail: Attn: Caleb Anderson
       Northern Maine Medical Center
       194 East Main Street
       Fort Kent, ME 04743
    b. Email: caleb.anderson@nmmc.org
    c. Fax: 207-834-1410

Please feel free to contact our Patient Financial Advocate at 207-834-1826 should you have any questions or wish to make an appointment.

FINANCIAL ASSISTANCE

Northern Maine Medical Center is committed to ensuring community members have access to affordable healthcare services. Two programs are available to eligible patients based on financial need.

FINANCIAL ASSISTANCE

Program may be able to cover

40%
50%
75%
100%

of non-elective visits and/or procedures

SLIDING FEE SCALE

This program offers a set co-pay amount of

$0
$15
$25
$40

for eligible patients in the clinic locations below.

Fort Kent Family Practice
Acadia Family Practice
Medical Office Building
Behavioral Health

Please contact our Patient Financial Advocate for assistance:

207-834-1826

Nondiscrimination Policy

As a recipient of Federal financial assistance, Northern Maine Medical Center does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, gender, color, national origin, disability, sex, sexual orientation, religion or the inability to pay or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Northern Maine Medical Center directly or through a contractor or any other entity with which Northern Maine Medical Center arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Right Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Social Work Department or Corporate Compliance

Provider Name: Northern Maine Medical Center

Contact Person/Section 504 Coordinator:
Sue Devoe, Director of Quality and Compliance Officer or James Reese, CNO
Telephone number:207-834-3155

TDD or State Relay Number: 207-834-4100

NOTICE OF AVAILABILITY OF MEDICAL ASSISTANCE

Financial Assistance Program	Northern Maine Medical Center is required by law to make available a reasonable amount of uncompensated services to persons eligible under applicable US DHHS guidelines. Patient eligibility for medical assistance is granted if the family income is not more than 200% of the current poverty guidelines established by the US Department of Health and Human Services. This program covers emergent and medically necessary services only and **does not** cover elective services.
Sliding Fee Program	In order to ensure that primary health care is made reasonably available to the people of this area without regard to ability to pay, a Sliding Fee based on family size and income is offered to established NMMC patients and their families. **Program applies to:** Fort Kent Family Practice, Medical Office Building, Acadia Family Health Center Family Practice and Behavioral Health.

100 % Covered by NMMC
0% Patient Responsibility
$0 Office Visit Co-Pay
150% or Below Income Range

Household/ Family Size	Minimum	Maximum
1	$ -	$ 23,475.00
2	$ -	$ 31,725.00
3	$ -	$ 39,975.00
4	$ -	$ 48,225.00
5	$ -	$ 56,475.00
6	$ -	$ 64,725.00
7	$ -	$ 72,975.00
8	$ -	$ 81,225.00
9	$ -	$ 89,475.00
10	$ -	$ 97,725.00
11	$ -	$ 105,975.00
12	$ -	$ 114,225.00
13	$ -	$ 122,475.00
14	$ -	$ 130,725.00

75% Covered by NMMC
25% Patient Responsibility
$15 Office Visit Co-Pay
150% to 175% Income Range

Household/ Family Size	Minimum	Maximum
1	$ 23,476.00	$ 27,387.50
2	$ 31,726.00	$ 37,012.50
3	$ 39,976.00	$ 46,637.50
4	$ 48,226.00	$ 56,262.50
5	$ 56,476.00	$ 65,887.50
6	$ 64,726.00	$ 75,512.50
7	$ 72,976.00	$ 85,137.50
8	$ 81,226.00	$ 94,762.50
9	$ 89,476.00	$ 104,387.50
10	$ 97,726.00	$ 114,012.50
11	$ 105,976.00	$ 123,637.50
12	$ 114,226.00	$ 133,262.50
13	$ 122,476.00	$ 142,887.50
14	$ 130,726.00	$ 152,512.50

50% Covered by NMMC
50% Patient Responsibility
$25 Office Visit Co-Pay
175% to 190% Income Range

Household/ Family Size	Minimum	Maximum
1	$ 27,388.50	$ 29,735.00
2	$ 37,013.50	$ 40,185.00
3	$ 46,638.50	$ 50,635.00
4	$ 56,263.50	$ 61,085.00
5	$ 65,888.50	$ 71,535.00
6	$ 75,513.50	$ 81,985.00
7	$ 85,138.50	$ 92,435.00
8	$ 94,763.50	$ 102,885.00
9	$ 104,388.50	$ 113,335.00
10	$ 114,013.50	$ 123,785.00
11	$ 123,638.50	$ 134,235.00
12	$ 133,263.50	$ 144,685.00
13	$ 142,888.50	$ 155,135.00
14	$ 152,513.50	$ 165,585.00

40% Covered by NMMC
60% Patient Responsibility
$40 Office Visit Co-Pay
190% to 200% Income Range

Household/ Family Size	Minimum	Maximum
1	$ 29,736.00	$ 31,300.00
2	$ 40,186.00	$ 42,300.00
3	$ 50,636.00	$ 53,300.00
4	$ 61,086.00	$ 64,300.00
5	$ 71,536.00	$ 75,300.00
6	$ 81,986.00	$ 86,300.00
7	$ 92,436.00	$ 97,300.00
8	$ 102,886.00	$ 108,300.00
9	$ 113,336.00	$ 119,300.00
10	$ 123,786.00	$ 130,300.00
11	$ 134,236.00	$ 141,300.00
12	$ 144,686.00	$ 152,300.00
13	$ 155,136.00	$ 163,300.00
14	$ 165,586.00	$ 174,300.00

If you believe you may be eligible for medical assistance and wish to request it, please contact:

Northern Maine Medical Center
Patient Financial Services Office
(207) 834-1826

NMMC will make a written conditional determination or a final determination of eligibility as follows: For requests made prior to discharge or prior to receipt of outpatient services, within 2 working days following the receipt of the request. For requests made after the discharge or after receipt of outpatient services, no later than the end of the first full billing cycle following the request. These time frames are contingent upon receipt of all required information.

NMMC FINANCIAL ASSISTANCE PROGRAM

Application is for

☐ **Financial Assistance Program** ☐ **Sliding Fee Scale** ☐ **Both**

SECTION ONE: PATIENT INFORMATION

Full Name		Address	
Phone Number	Date of Birth		
Email		Marital Status ***(Optional)***	Number of Dependents
Current Health Insurance		Occupation	

SECTION TWO: INCOME INFORMATION

Along with the information listed below, please provide a copy of most recent tax return or last 3 paystubs.

Income Source	**Self**	**Spouse**
Wages / Self-Employment / Social Security		
Unemployment or Worker's Compensation		
Child Support (only if you are the recipient)		
Rental Income / Pension / Dividends / Other		

SECTION THREE: HOUSEHOLD INFORMATION

Name of Family Member	**Age**	**Relationship**

SECTION FOUR: SIGNATURE

I certify that the information submitted on this form is true and accurate to the best of my knowledge. I understand that all information submitted may be verified by NMMC. I authorize verification of this information.

Signature	Date

northern maine
MEDICAL CENTER

Care you *count on.*
People you *trust.*

Attestation of Zero Income and Financial Support

1. I, _____, hereby certify that I do not individually receive income from any of the following sources:
    a. Wages from employment (including commissions, tips, bonuses, fees, etc.);
    b. Income from the operation of a business;
    c. Rental income from real or personal property;
    d. Interest or dividends from assets;
    e. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;
    f. Unemployment or disability payments;
    g. Public assistance payments;
    h. Periodic allowances such as alimony, child support, or gifts received from persons not living in my household;
    i. Sales from self-employed resources;
    j. Any other sources not named above.
2. Choose one:
   Currently, I have no income of any kind and while I am seeking employment, there is no definite job offer at this time.
   Currently, I have no income of any kind and I will not be seeking employment at this time.
3. I will be using the following sources of funds to pay for rent and other necessities:
   _____

4. The following individual attests that they provide financial support for the aforementioned patient:

_____	_____	_____
Printed Name	Signature	Date

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in a denial of Financial Assistance.

_____	_____	_____
Patient Name	Patient Signature	Date