Cary Medical Center
163 Van Buren Road
Caribou, ME 04736
207-498-1617
billinghelp@carymed.org
www.carymedicalcenter.org

CARY MEDICAL CENTER SLIDING FEE DISCOUNT PROGRAM

IMPORTANT!

HOW THE FINANCIAL ASSISTANCE PROGRAM WORKS

- Patients in our Financial Assistance Program (FAP) can get discounts for many services.
- Assistance is based on household income and size.
- Annual Federal Poverty Guidelines set income ranges for this program.
- This program is NOT health insurance.
- This program only covers Cary Medical Center services.
- CMC works with other healthcare providers, please ask them if they offer a Financial Assistance Program or similar.

To apply for the program, you may visit us at the address listed below or you may find an application on our website at
https://www.carymedicalcenter.org/finance-billing/financial-assistance/

For further questions on the program, please contact our office at (207)-498-1617, *option 3* or email – billinghelp@carymed.org

Applications should be submitted to one of the following to be processed:

- Completed in full and dropped off with the Front Desk in the Main Lobby at Cary Medical Center located at:
  163 Van Buren Road Suite 1, Caribou, ME 04736
- Completed and emailed to billinghelp@carymed.org
- Mailed to:
  163 Van Buren Road, Suite 1
  ATTN: Financial Counselor
  Caribou, ME 04736

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CARY MEDICAL CENTER
Financial Assistance Program Application

Applicant Information:

Applicant Name: _____ Date of Birth: _____

Mailing Address: _____

Phone Number: _____ Marital Status: _____

Social Security Number: _____

Employer Name: _____ Tax Filer (circle): YES or NO

Hire Date: _____ If not employed – last date worked: _____

Please explain if not employed: _____

Insurance Information (if applicable): _____

Are you an active or retired Veteran? (circle): YES or NO

Co Applicant Information (Married/Domestic Partner Information):

Co Applicant Name: _____ Date of Birth: _____

Mailing Address: _____

Phone Number: _____ Marital Status: _____

Social Security Number: _____

Employer Name: _____ Tax Filer (circle): YES or NO

Hire Date: _____ If not employed – last date worked: _____

Please explain if not employed: _____

Insurance Information (if applicable): _____

Are you an active or retired Veteran? (circle): YES or NO

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Members of Household & Mainecare Information

Please list names and birthdates for you and all members of your household.

- If you file taxes or you are claimed as a dependent, your household is you and anyone else listed on the tax return.
- If you do not file taxes and are not claimed as a dependent by anyone else, your household is you, your spouse, and your children that live with you.
- For divorced/separated/joint custody parental relationships – dependent children may only be listed on one program application.
- Financially co-dependent unmarried couplies living together with mutual children will be counted as one household.
- All married couples will be counted as a household.

TOTAL NUMBER IN HOUSEHOLD: _____

Name	DOB	Relationship to Applicant	Gross Income (before deductions)	Income Source

A MaineCare approval/denial letter is required with this application

Have you applied for Medical Coverage through the Department of Health and Human Services? (circle)
YES or NO If yes, please list the date you applied: _____

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Income Worksheet:

Please provide the following information that is applicable to you and your household:

If anyone in the household has:	✓	Amount Paid/How Often	You must provide copies of:
Wages & Salaries from an employer			Three months of most recent paystubs OR most recent paystub with employee start date & year to date income amount listed.
Self-Employment or Rental Income			Last year's tax return and ALL supporting schedules. Last 3 months rental receipts to show gross rental income.
Capital Gains, Dividends, Interest.			Most recent tax filing.
Unemployment Benefits			Unemployment benefit letter OR Weekly Claims report showing current gross income. To request a letter, call 1-800-593-7660.
Workers' Compensation Benefits			Workers Compensation benefits award letter showing gross distribution.
Short/Long Term Disability Benefits (SSI/SSDI)			Most recent pay stubs showing gross income for disability benefits for the last three months.
Social Security or Disability Income (SSI/SSDI)			Current year award letter. You can request a copy of your benefit award letter by calling 866-837-2719.
Retirement benefits			Benefit letter or statement (if 401K, IRA, etc…) showing gross amount distributed.
(or pays) Alimony or Child Support			Record of payments received or copy of the court order. Record of payments paid (bank statement, copy of check, etc.)
TANF			Benefit determination letter.
No Income			Statement of Support (attached here)

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Statement of Support for Applicants with no Income:

Applicant Name: _____ Date of Birth: _____

Please check one that applies to you:

A. Signature of family member, friend or other is required if:

- ○ I do not have income to support myself and either live with someone or have someone who supports my daily living expenses.
- ○ I do not have income to support myself and I am homeless or couch-surfing.
- ○ I do not have income and I am assisted by an agency for housing, food or other daily needs.
- ○ I do not have income and am supported by savings.
- ○ I do not have income and am supported solely by Financial Aide (FAFSA).
- ○ I have income to support myself but do not file a Federal Tax Return. Profit & Loss Statement required.

B. Signature of shelter or housing staff is required if:

- ○ I do not have income to support myself and am living in a shelter or transitional housing.

- ➢ I certify that all my answers are correct and complete as far as I know.
- ➢ I will tell Cary Medical Center about any changes in my health insurance or family income.
- ➢ I understand that if I give false information, I will be disqualified from the program.
- ➢ I understand that this program is NOT health insurance.

***** Applicant signature date is the effective date *****

Applicant Signature: _____ Effective Date: _____

Co-Applicant Signature: _____ Date: _____

A. Signature of Shelter or Transitional Housing Staff: _____ Date: _____

B. Signature of Family Member, Friend or Other: _____ Date: _____

Relationship to applicant: _____

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MEDICAL CARE FOR THOSE WHO MAY QUALIFY FOR FINANCIAL ASSISTANCE

In accordance with Chapter 150, Section 1 Hospital Finance Rules, Cary Medical Center will provide **Financial Assistance** to residents of the State of Maine whose income falls below the following guidelines:

		Percentage of Poverty		
Federal Guidelines	**Family Size**	**0-190%**	**191-200%**	**201-210%**
		100% Write Off	**75% Write Off**	**50% Write Off**
$15,650	**1**	**$29,735**	**$31,300**	**$32,865**
$21,150	**2**	**$40,185**	**$42,300**	**$44,415**
$26,650	**3**	**$50,635**	**$53,300**	**$55,96**
$32,150	**4**	**$61,085**	**$64,300**	**$67,515**
$37,650	**5**	**$71,535**	**$75,300**	**$79,065**
$43,150	**6**	**$81,985**	**$86,300**	**$90,615**
$48,650	**7**	**$ 92,435**	**$97,300**	**$102,165**
$54,150	**8**	**$102,885**	**$108,300**	**$113,715**

For family units larger than 8, add $5,500 per year for each additional person

If you believe you qualify for Free Care, please contact the Financial Counseling Office at:

Phone: 207-498-1617
800-858-2279 ext. 1617
Email Address: billinghelp@carymed.org

Before providing financial assistance, the hospital will ask for information about your income and ask you to verify that insurance or government medical assistance programs will not pay for your care.

Only services that are medically necessary are provided within our Financial Assistance Program.

Individuals can access our application on our website, www.carymedicalcenter.org or by visiting our Financial Counseling Office located at:

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If you disagree with the determination, you may ask for a fair hearing. We can explain how to apply for a fair hearing.

The above guidelines are effective February 3, 2025.