Free care application

New England Rehabilitation Hospital of Portland
a Joint Venture of Maine Medical Center and Encompass Health

Applicant Information

Name		DOB *(MM/DD/YYYY)*	SSN *(last four digits)* ___ ___ ___ ___
Address	City/State/Zip		Phone
Marital Status	Employer(s) (list all for the last 3 months)		Start Date(s) and Salary/Wage
Insurance (if none, indicate N/A)	Policy # (if applicable)		Effective Date (if applicable)

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

Name		DOB	SSN *(last four digits)* ___ ___ ___ ___
Phone #	Employer(s) (list all for the last 3 months)		Start Date(s) and Salary/Wage

In the case that applicant is married but separated from spouse, a copy of the legal separation or divorce filing is required.

Dependents (qualifying child or qualifying relative for whom you can claim a tax exemption according to IRS rules)

Name	DOB	Relationship to Applicant	MaineCare ID #

Household Income for the last 3 months (*Applicant and their household must provide previous year's complete federal tax return.)*

If Household Receives:	**Amount per Month:**	**Applicant Must Provide:**
Earnings/wages from employer(s)	$	3 months of paystubs or pay detail report from each job showing gross income AND previous year's complete federal income tax return.
Self Employed/Rental income	$	12 months profit & loss statement AND previous year's complete federal tax return.
Unemployment, STD, LTD or workers' comp benefits	$	Weekly Claims report showing last 13 weeks or 6 months gross income.
Social Security or SSDI	$	Current year benefit letter. To request a copy of your benefit letter, call 1-877-405-1448 or visit www.ssa.gov. 1099 Form not acceptable
Retirement or Pension Benefits	$	Benefit letter or statement (401K, IRA, etc.) showing gross amount distributed. 1099 Form not acceptable.
General Assistance	$	Current month General Assistance benefits letter.
Alimony/Child Support	$	Copy of court order OR 2 checks/receipts.
Dividends/Interest	$	Quarterly dividend statements OR 3 months of bank statements.
Other	$	Lottery winnings, non-wage earnings, cash for odd jobs, etc. for the last 2 months.

Note: Free Care applies only to hospital charges, and does not apply to fees for private practice physicians such as radiologists or other specialists, and non-hospital employed providers.

Send completed application form and documents to:	New England Rehabilitation Hospital of Portland Attn: Accounting 335 Brighton Avenue, Unit 201 Portland, ME 04102-2374	Email: FreeCarePortland@encompasshealth.com Fax: (207) 662-8446

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 by New England Rehabilitation Hospital of Portland. 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 Free Care, and that I will be liable for charges for services provided.

Applicant Signature _____ _____ ***Co-Applicant Signature*** _____ _____
Date ***(or patient representative)*** ***Date***

BUSINESS OFFICE USE ONLY

☐ APPROVED
☐ DECLINED
☐ ADDITIONAL INFORMATION REQUIRED _____

_____ _____
CEO DATE

_____ _____
CONTROLLER DATE