



# Franklin Community Health Network

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## Financial Assistance Application

### About Financial Assistance

Franklin Community Health Network provides quality care to all of our patients, regardless of their ability to pay. Our financial assistance program helps people without health insurance, or enough health insurance, pay for medical services. The program covers services at Franklin Memorial Hospital, Franklin Health Medical Practices and Northstar Emergency Services. Depending on your income, you may be eligible for a reduction in your bill.

### Please Provide the Following Information:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Doctor \_\_\_\_\_ SS# \_\_\_\_\_

Street/PO Box \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_ Phone# \_\_\_\_\_

**Marital Status** (circle one)      Married      Single      Divorced      Widowed

**Spouse/Significant** \_\_\_\_\_ DOB \_\_\_\_\_ Doctor \_\_\_\_\_ SS# \_\_\_\_\_

(significant other should only be included on the application if you have children together)

### **Dependent children/other people that live with you that you are legally financially responsible for:**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_ Doctor \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_ Doctor \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_ Doctor \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_ Doctor \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_ Doctor \_\_\_\_\_

### **Is anyone in your household covered by commercial insurance, Mainecare and/or Medicare? Y/N**

If yes, please provide coverage name & policy number(s).

\_\_\_\_\_

### **Would you like to be contacted by someone in our office about help with the cost of prescription medications? Y/N**

Please complete both sides >>>>

**Income**

Total Gross Household Income in last 12 months: \$ \_\_\_\_\_ (ex: current Federal income tax)

**OR**

Total Gross Household Income in last 13 weeks: \$ \_\_\_\_\_ (ex:13 consecutive paystubs)

\*Please call if you have any questions as to what you should provide

**Please attach proof of income. Income includes the following:**

*Money wages and salaries before any deductions, Net receipts from non-farm or farm self-employment, social security, railroad retirement, unemployment compensation, workers compensation, strike benefits from union funds, veteran’s benefits, Temporary Assistance to Needy Families, Supplemental Security Income, General Assistance money payments, Training stipends, Alimony, child support, military family allotments, private pensions, government employee pensions, regular insurance or annuity payments, Income from dividends, interest, rents, royalties or periodic receipts from estates or trusts, and net gambling or lottery winnings.*

**The above statements are true and completely disclose my household’s gross income.**

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Applicant’s Signature Date

**To determine if you are eligible, please follow these steps:**

1. Attach proof of income from the past 13 weeks (check stubs, bank statements, SS/SSI letter, W2 forms, or current income tax return). If you bring in original documents, we will make copies for you.
2. Complete and return this application to Franklin Community Health Network, Attn: Financial Counselor, 111 Franklin Health Commons, Farmington, Maine 04938.

Written notification of your approval or denial will be mailed to you after receipt of your completed application and required attachments. For more information, please contact us at 207-779-2396 or 207-779-3158. You may also email us at [financialcounselor@fchn.org](mailto:financialcounselor@fchn.org).

**If you have not had income in the past 13 weeks, please complete the following**

For the purpose of applying for financial assistance, I \_\_\_\_\_, certify that I have not had any income for the last 13 weeks.

Briefly explain how you and your household have managed to pay for necessary living expenses such as food, shelter, and utilities:

\_\_\_\_\_  
\_\_\_\_\_

The above statements are true and completely disclose my household’s gross income. I understand that a credit check may be obtained by Franklin Community Health Network. I further understand that I may be required to apply for government assistance (such as the MaineCare program) before a determination concerning financial assistance may be processed.

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Applicant’s Signature Date

For a complete listing of our “Paying for Care” programs visit  
[www.fchn.org/payingforcare](http://www.fchn.org/payingforcare)

