



Dear Applicant:

Martin's Point Health Care (Martin's Point) understands that some patients have limited resources to pay for services received at our Health Care Centers. Recognizing this, we have developed a financial assistance program to help eligible patients with their Martin's Point medical bills. The application process allows Martin's Point to gather enough information to verify true need and to make a fair and accurate determination of financial assistance eligibility.

The following items are included in this packet:

- Financial Assistance Income Guidelines
- Application for Financial Assistance
- Questionnaire to Determine if MaineCare/NH Medicaid Application Is Required

If an applicant's annual income is 175% to 250% of the federal poverty guidelines, that applicant is eligible for partial financial assistance (25%, 50%, or 75%) if he or she maintains the agreed-upon payment plan.

Applicants must exhaust all potential payment options before Martin's Point considers financial assistance.

Please note the following restrictions:

- **Medical Necessity:** Only medically necessary services are eligible for financial assistance. This does **not include** cosmetic procedures or services, bariatric services, sterilization/birth control, fertility services, travel medicine, over the counter medications and medications for weight loss, smoking cessation, or cosmetic reasons.
- **Prescription Drugs:** Financial assistance does **not** cover prescription drugs beginning 1/1/2025. Patients will need to work directly with their external Pharmacy to identify any prescription assistance that may be available through other organizations.
- **Laboratory Services:** Only work performed by a Martin's Point laboratory is eligible for the financial assistance program. Please note that some lab work is drawn at Martin's Point, but sent to an outside lab for analysis. Lab work performed at Quest Diagnostics, NorDx, or other non-Martin's Point labs is **not eligible** for financial assistance. You will receive an additional bill for any lab services rendered by any non-Martin's Point providers. The patient is responsible for full payment for these services when performed by a non-Martins Point provider. The patient may contact the non-Martins Point provider to see if they offer financial assistance.
- **Radiology Services:** Only radiology services performed by Martin's Point providers are eligible for the financial assistance program. Sometimes, non-Martin's Point radiologists read imaging obtained through the Martin's Point Radiology department. In this case, you will receive an additional bill for professional services from the outside radiologist. The patient is responsible for full payment for these services.
- **Specialty Services:** Martins Point providers may refer our patients to a non-Martins Point provider for specialty services, including physical therapy, chiropractic, durable medical equipment, etc. The patient is responsible for full payment for these services when performed by a non- Martins Point provider. The

patient may contact the non-Martins Point provider to see if they offer financial assistance.

If you have questions about lab, radiology, or specialty care bills you receive from non-Martin's Point providers, please contact the rendering provider/facility directly to ask them about payment and assistance options.

Before applying for financial assistance, you must:

- Review and compare your income for the past 12 months (or the past three months and estimate 12 months income) to the Financial Assistance Income Guidelines included in this packet.
- Complete the MaineCare/New Hampshire Medicaid questionnaire on page 6 to determine if you are required to apply for one of these programs.
- **If you check 'yes' for any of the questions on this questionnaire**, you must first apply for coverage with MaineCare or NH Medicaid. See additional requirements on page 5.

To apply for the Martin's Point financial assistance program:

Please return the following to our Patient Accounts department at the address below:

- Completed, signed, and dated Application for Financial Assistance
- Income verification for the past three months (i.e., copies of pay stubs, employer statement, etc)
- A MaineCare/New Hampshire Medicaid denial letter, if required
- Previous year's Federal Tax Return

After reviewing your information, Martin's Point will send you a letter indicating its decision. If you have any questions, please call the Patient Accounts department at 1-800-499-7875.

Thank you,

Patient Accounts Department Martin's
Point Health Care
PO Box 9746
Portland, Maine 04104

Financial Assistance Income Guidelines

Revised 03/20/2024

Family Members	Federal Poverty Guideline (FPG)	175% of FPG	200% of FPG	225% of FPG	250% of FPG
1	\$15,060	\$26,355	\$30,120	\$33,885	\$37,650
2	\$20,440	\$35,770	\$40,880	\$45,990	\$51,100
3	\$25,820	\$45,185	\$51,640	\$58,095	\$64,550
4	\$31,200	\$54,600	\$62,400	\$70,200	\$78,000
5	\$36,580	\$64,015	\$73,160	\$82,305	\$91,450
6	\$41,960	\$73,430	\$83,920	\$94,410	\$104,900
7	\$47,340	\$82,845	\$94,680	\$106,515	\$118,350
8	\$52,720	\$92,260	\$105,440	\$118,620	\$131,800
Write-off (WO) Qualification		100% WO	75% WO	50% WO	25% WO

Source: Federal Register February 1, 2024

A family member is a spouse, partner, or child under the age of 18 sharing residence with the applicant, or an adult child up to age 26.

For families above eight members: Add \$9,415 for each additional family member under 175% of the federal poverty guideline. For qualifying for a sliding fee, add \$10,760 for 200%, \$12,105 for 225%, and \$13,450 for 250% for each additional family member.

Income

List all gross income for yourself, spouse, and other family members below (a family member is a spouse, partner, or child receiving monthly disability, or an adult child sharing residence up to age 26):

	Total for Past 3 Months	Total for Past 12 Months
Wages	\$	\$
Farm or Self-Employment	\$	\$
Short/Long-Term Disability Benefits	\$	\$
Social Security/Disability Income (SSI/SSDI)	\$	\$
Retirement Benefits/Pension/Worker's Compensation	\$	\$
TANF/General Assistance Benefits	\$	\$
Alimony/Child Support	\$	\$
Military Family Allotments	\$	\$
Assistance from Friends/Family	\$	\$
Pensions	\$	\$
Income from Dividends, Interest, Rent	\$	\$
Other	\$	\$
Totals	\$	\$

Questionnaire to Determine if MaineCare/NH

Medicaid Application Is Required

Please check 'yes' if this applies to you or to anyone for whom you are asking coverage:

- | | | |
|--|------------------------------|-----------------------------|
| Are you under age 21 or age 65 or older? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Are you physically or mentally disabled? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Were you unable to work for the past 12 months due to a medical condition? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Are you currently pregnant? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Are you legally blind? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Are you the primary caretaker for a child under age 18? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If you have checked 'yes' for any of these questions, you must first apply for coverage with MaineCare or NH Medicaid. If MaineCare/NH Medicaid denies you medical insurance, send a copy of the denial letter to the Martin's Point Patient Accounts department. Please send us your determination letter so that we may process your application. If you answered 'no' to all questions, you are not required to apply first for MaineCare/NH Medicaid coverage.

Household Members

Name

Age

Relationship

I affirm that the information provided, including income, is true and correct to the best of my knowledge. I understand that the information that I provide concerning my income and family size is subject to verification. I also understand that, if the information provided by me is determined to be false, such determination will result in a denial of financial assistance and that I will be liable for charges for service provided.

Signature _____ Date _____