Dear Customer,

Thank you for choosing St. Mary's Regional Medical Center (St. Mary's) and/or Community Clinical Services (CCS) for your care. We want you to have a pleasant experience.

This Plain Language Summary explains financial assistance programs for St. Mary's and CCS. We offer a Free Care Program and a FQHC sliding-fee discount.

Who Qualifies?
Free Care and the FQHC discount are for persons or households

- who are Maine residents
- who have income below 200% of poverty level; and
- who either have no insurance or have out-of-pocket expenses after insurance has been applied

How to Apply
To apply for this assistance, submit the following information:

- Copy of valid state ID (driver's license or state-issues photo ID)
- Proof of income for the most recent 13-weeks (See Financial Assistance application for acceptable documents)
- Denial letter from the Department of Human Services, if applicable
- Completed Financial Assistance application

We will return any incomplete applications. If a returned application becomes more than 90-days old, you will need to start a new application.

Rules
If your application is approved, you will receive discounted or free care for 6 or 12 months. If you are admitted as an inpatient or receive inpatient services 30-days or more after we approve your application, you may be requested to reapply. If you were covered by insurance that we did not know about, you will lose your financial assistance and must pay fully for any services that were adjusted.

What Is Covered?
Free Care services

- performed within 240-days before the date on the bill
- performed by providers employed by St. Mary's and billed by St. Mary's
- medically necessary (see attached services that are NOT medically necessary)

FQHC Discount services

- performed within 240-days before the date on the bill
- performed by providers employed by CCS and billed by Community Clinical Services
- medically necessary (see attached services that are NOT medically necessary)

Note: Financial Assistance does not apply to services by a non-employed provider; unless indicated (such as, but not limited to, radiologists, pathologists, and anesthesiologist)

More Information
Please contact our Financial Counselors at (207) 777-8208 if any of the following are true:

- You have insurance coverage that you did not disclose to us
- You do not qualify for financial assistance but need help
- You with to set up a payment arrangement

To apply for Financial Assistance, follow the instructions on the attached application.
Sincerely,

Patient Financial Counselor/ Patient Representative Services
207-777-8208

Non-Medically Necessary Services

*Acupuncture
*Admission Not Certified by Utilization Review
*Breast Pump Rental
*Cardiac Rehab Phase III
*Cat Scans for Lung Screening
*Child Birth Class
*Circumcision
*Cosmetic Surgery; Breast Reconstruction, Breast Reduction/Mastopexy, Removal of Excess Skin and Subcutaneous Tissue of Abdomen, Skin Tag Removal for Cosmetic Purposes, EVLT (Endovenous Laser Treatment) for Cosmetic Purposes.
*Gastric Bypass, Gastroplasty, Gastric Banding (unless deemed to be medically necessary)
*Infertility Services
*IOP/Intensive Outpatient Patient Behavioral Program(s)
*Medical Care by Mail, Telephone or Internet
*Migraine Procedures (unless deemed to be medically necessary)
*Off-label Procedures (unless deemed to be medically necessary)
*Pre-certification Denials for Medical Necessity and an Advanced Beneficiary Notice (ABN) is issued
*Preparation and Duplication of Records, Forms and Reports
*Private Room(s)
*Procedures for altered gender
*Reversal of Sterilization Procedures
*Services Not Covered by the Primary Insurance/Payer due to Services Not Being Authorized
*Services received at d/b/a St. Mary's d'Youville Pavilion
*Services that the patient elects under the HIPAA Privacy Act to not have billed to his/her health insurance and instead elects to pay for the services in full. These services may be medically necessary, but would not be eligible for this program when another payer source is available, but the patient elects not to utilize it.
*Utilization Review denials for medical necessity and a Notice of Non-Coverage is issued
*Weight Management Program
*Other; Non-employed provider (unless otherwise noted in policy addendum), Radiologist, Pathologist, Anesthesiologist, and any services not billed by St Mary's Regional Medical Center and Community Clinical Services.

If not noted, St. Mary's Regional Medical Center reserves the right to follow the Medical Necessity and Medically Necessary rules as outlined in the Maine Department of Health and Human Services 10-144, Chapter 101, MaineCare Benefits Manual.

The FQHC Sliding-fee Discount is only for (new) and existing patients of Community Clinical Services, the Federally Qualified Health Center (FQHC). Community Clinical Services offers primary care services with convenient locations in Lewiston and Auburn Maine.

In liability or MVA situations, proof of valid insurance denial or exhaustion of benefits must be provided before claims will be considered for this program.

ST. MARY'S REGIONAL MEDICAL CENTER
A Member of Covenant Health

COMMUNITY CLINICAL SERVICES INC.
FQHC - Federally Qualified Health Centers
AFFILIATED WITH ST. MARY'S HEALTH SYSTEM

Financial Assistance Program Application
Application for Free Care and FQHC Sliding-fee Discount
Free Care_____ FQHC (CCS-Maine)_____

Patient Information

Patient Full Name			
Address			
Date of Birth	Social Security #	Phone#	Other Phone#
Employer Name			If not employed, date of last day of work:
Insurance, if any			

Additional Family/Household Member Information

Family/Household Member Name	Date of Birth	State of Maine Resident? **Yes or No**	Social Security #	Employed? **Yes or No**	Health Insurance? **Yes or No**

Household Income

Proof of household income for the past 13-weeks is REQUIRED for all family members and household individuals noted on the application. Income is defined as the total amount of money paid to you annually before payment of Social Security and income taxes. Sources of income, but not limited to, wages, salaries, tips, taxable interest, taxable amount of pension, annuity or IRA distributions, annual dividends, Social Security benefits, VA benefits, unemployment, TANF, General Assistance, stipends, child support, alimony, worker's compensations benefits, rental real estate income, royalties, partnerships, S Corps, trusts, taxable refunds, credits or offsets of state and local income taxes. If you are self-employed, provide a copy of the previous year's income tax return, including the Schedule C. If you are being claimed as a dependent on another individual tax return, you must provide a copy of that return and the person's most recent paystubs in addition to your own. If you have no source of household income for the past 13-weeks, you must complete the Limited Income Statement below.

Limited Income Statement

By signing below, I declare that I and the other individuals noted on this application have not received any income for the past 13-

weeks. Sources of income include but are not limited to the sources noted in the Household Income section above and any under-the-table payments. I understand that I will not be approved or will lose approval if I provide any false information. I declare that the information in the application is accurate and correct.
If you have no income, explain your living situation (food/shelter/etc.):
Applicant Signature: **Date:**

Financial Assistance Screening (All questions must be answered)	Circle **Yes or No**
Is anyone in the household covered by health insurance or health savings accounts?	YES NO
Is the applicant eligible for Medicare (Medicare Part A &/or B)?	YES NO
Is the applicant receiving SSDI or SSI (Social Security benefits)?	YES NO
Has anyone in your household served in the Military?	YES NO
Have you or anyone in your household filed a worker's compensation or motor vehicle accident claim? If so, date of claim: _____ Name of family member involved: _____	YES NO
Does the applicant have a mental or physical disability that will prevent him/her from working?	YES NO
Does the applicant have a terminal illness?	YES NO
Does the applicant have minor or dependent children within the same household?	YES NO
Is the applicant or anyone noted on the application pregnant?	YES NO
Is the applicant, family member or anyone in the household eligible for or have MaineCare (Maine Residents)?	YES NO

Applicant, family member and/or household member MaineCare information, if any.

Name	Medicaid/MaineCare ID #	Effective Date	Date Verified

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Note to Applicants and Assignment of Rights (Read Carefully)

By signing below:
I permit the request for proof of income as noted above. I understand that I may need to provide a copy of my tax return. I understand that more information may be requested.
I permit the release of any medical, financial, or employment information that relates directly to my health care or to my financial assistance eligibility. This information may be released to any health care providers from whom I and any household members have received health care services or financial assistance. All information provided will remain confidential under HIPAA federal regulations. Any discounts apply to all balances within the approved period for medically necessary services provided by St. Mary's and/or Community Clinical Services.
If I am approved for Financial Assistance:

- I understand that I will the assistance if I have not fully and correctly presented my income, if I have provided any false information, or if I have not disclosed my insurance coverage. If I lose the assistance, I agree to pay the balance on my account. I also agree to pay any legal fees for the collection process.
- I agree to repay any money if I receive other payment for the medical services covered. Such payments may include insurance payments, governmental program programs, and awards from a lawsuit.
- I agree to tell St. Mary's of any changes that could affect my eligibility, including changes to family size, income, and health insurance coverage. If I might qualify for a public assistance program, I will apply to that program and provide St. Mary's with the proof of application.

Applicants Signature: _____Date: _____

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Inpatient Financial Assistance Revalidation

Patient Full Name	
Date of Admission	Patient Account Number
Has patient or family household income changed as previously presented on the most recent application? If yes that the income has changed, patient must provide new proof of income as outlined in the policy.	YES NO

Note to Applicants and Assignment of Rights (Read Carefully)

By signing below, I authorize the request for my income as noted above. I understand that a tax return may be needed to process this application and that more information may be requested before my eligibility can be determined.
In the event that I have not fully disclosed, or have inaccurately represented, any income, falsified any information, failed to provide active insurance coverage for the favorable period, any agreement to provide you with a financial assistance discount would be null and void and would be retroactive back to the date the bills were owed. I may be liable for any/all legal fees during the collection process.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of the HIPAA federal regulations. Approved adjustments apply to all balances whose income falls below or at 200% of the Federal Poverty level and falling within the eligible period, excluding services that are found not to be medically necessary; as noted within the facilities policies.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, aware from a lawsuit or any other payment.
If I am approved and receive Financial Assistance, I agree to tell the organization of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for public assistance program, I will need to apply to that program and provide proof of application.

Applicants Signature: _____Date:_____