INTERMED
Care without compromise.

Financial Hardship Application

Please complete the financial disclosure form (Page 3 & 4) and provide documentation of proof of household income. One of the following is needed for appropriate proof of income:

- Pay stubs from the last 90 days
- Recent forms from MaineCare or other state-funded assistance
- Any other proof of income
- If you have been denied for MaineCare or any other assistance, please provide a copy of the denial

Eligibility:

- Third parties who may be liable for payment are excluded from coverage of this policy. Access to one discount policy only per patient/family.
- Only medically necessary services are eligible for use of this policy. Cosmetic services or services that are not deemed medically necessary by the payer are excluded from coverage of financial assistance.
- Patients must complete a financial hardship application and provide proof of income for the preceding 3 months.
- All financial documents must be provided within 10 business days of the application for assistance. Otherwise, assistance will be denied for lack of documentation.

Eligibility Period:

- The patient's account will never be permanently designated as financial hardship. The status of financial hardship for purposes of the discount will be effective for 6 months. Once the term has ended, the patient would need to reapply and provide recent income information.
- The patient may be awarded the discount for services incurred up to a maximum of 3 months prior to the effective date of financial hardship designation.

Income will be annualized from the date of the request based on documentation provided. Any denial of "financial hardship" discount request will be written and include instructions for reconsideration. **All information relating to financial hardship request will be kept confidential.**

INTERMED
Care without compromise.

Financial Hardship Application

If you have any questions regarding the financial hardship application process, please call the business office customer service at (207) 828-0361.

Guidelines used to determine financial hardship based on income.

Persons in Family	2023 Federal Poverty Guideline	150% Poverty Level: InterMed, P.A. 100% Financial Assistance	175% Poverty Level	200% Poverty Level
1	$14,580	$21,870	$25,515	$29,160
2	$19,720	$29,580	$34,510	$39,400
3	$24,860	$37,290	$43,505	$49,720
4	$30,000	$45,000	$52,500	$60,000
5	$35,140	$52,710	$61,495	$70,280
6	$40,280	$60,420	$70,490	$80,560
7	$45,420	$68,130	$79,485	$90,840
8	$50,560	$75,840	$88,480	$101,120
Qualifying %	**100%**	**100%**	**50%**	**25%**
For each additional person, add	$5,140	$5,140	$5,140	$5,140

Source: Medicaid.gov, January 2023; 2023 Federal Poverty Level Charts

---

Please provide all applicable documents listed below so we may complete your application:

- Pay stubs for the past 90 days for all persons employed in the home
- Unemployment pay stubs for the past 90 days
- Proof of all other income for the past 90 days
- Denial from MaineCare or any other assistance requested

INTERMED
Care without compromise.

Financial Hardship Application

Please sign the financial disclosure form after completion. Your application will not be processed if not signed. Return all items by mail in the self-addressed envelope or in person.

Financial Disclosure Form

Patient's Name: _____

Patient's Date of Birth: _____

If applying for a family, please add additional patients below:

Patient Name	Date of Birth

Date(s) of Service: _____

Name of Responsible Party: _____

Relationship to Patient: _____

Telephone Number: _____

Address: _____

Employer: _____

If unemployed, how long? _____

Do you have medical insurance: __ Yes __ No

If yes, please provide insurance information:

Insurance Name: _____ Policy ID Number: _____

INTERMED
Care without compromise.

Financial Hardship Application

(Continued on other side)

Financial Disclosure Form

Monthly Family Income: __ Patient __ Spouse __ Responsible Party

Income Type	Monthly Amount
Salary/Wages	
Public Assistance Benefits	
Unemployment Benefits	
Social Security Benefits	
Workman's Compensation	
Other	
Total	

I hereby acknowledge that the information given herein is true and correct. I authorize InterMed, P.A. to verify information contained in this document for the sole purpose of assessing financial need.

_____ _____
Signature Date

_____ _____
Print Name Date

For Office Use Only

○ Approved
○ Denied Reason: _____

Date: _____ Completed By: _____

Notification Sent: _____
Notification Date: _____