REQUEST FOR DETERMINATION
OF ELIGIBILITY FOR FREE CARE

PATIENT NAME:		**DATE OF BIRTH**:	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE NUMBER:	**DATE OF SERVICE:**	**LAB NUMBER:**	
RESPONSIBLE PARTY NAME:		**MARITAL STATUS:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
INSURANCE NAME, IF ANY:		**POLICY NUMBER:**	
EMPLOYER:	**OCCUPATION:**	**RATE OF PAY:**	

SIZE OF FAMILY:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

INCOME (List all income for yourself, spouse, and other dependents, from any of the following**)**

- ☐ Wages $ _____
- ☐ Self-employment $ _____
- ☐ Unemployment $ _____
- ☐ Workers Comp $ _____
- ☐ Alimony / Child Support $ _____
- ☐ Pensions $ _____
- ☐ Rental Prop Income $ _____
- ☐ Dividends & Interest $ _____
- ☐ Public Assistance $ _____
- ☐ Lottery Winnings $ _____
- ☐ Other $ _____

TOTAL **$ _____**

Proof of income is required. Please provide the following:

- ☐ If self-employed, most recent tax return
- ☐ Income Tax Forms, valid January through April **only**
- ☐ Four most recent pay stubs, including year-to-date totals from all employers
- ☐ Written explanation of current situation - Notarized
- ☐ Other proof of your income

Have you been approved for Free Care at another MaineHealth Facility? Yes:__ No: __

If so what facility? _____

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 NorDx. I also understand that if 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.

Signature of Person Making Request	Relationship to Patient	Date of Request
_____	_____	_____

Send completed to:

NorDx
301A US Route One
Scarborough, ME 04074

Contact NorDx at:
(207) 396-7820

For Office Use Only:

150% FPL / 100% _____
175% FPL / 100% _____
200% FPL / 50% _____
225% FPL / 25% _____

Reimbursement Staff	Date
_____	_____

Approving Signature	Date
_____	_____