2020 HELP Application
(Help at Every Level Program)

THE PROGRAM:

The Help at Every Level Program offers reductions on patient hospital bills based on visit/s relating to one encounter, household income and the amount owed.

QUALIFICATIONS/REQUIREMENTS:

Bills must have a patient balance of $1,000 and over.
One outstanding bill or multiple balances which must relate to the same visit/event as determined by York Hospital.
Application and requested documentation showing last 12 months of income.
Payment must be made in full (one- installment within 60 days) from date on discount coupon.
Some procedures may be excluded, please inquire at the time of applying.

ELIGIBILITY:

Please refer to the below chart to determine eligibility.

	AMOUNT OWED TO YORK HOSPITAL								
Household Income Level	Balance $1,000-$5,000	Balance $5,001-$7,500	Balance $7,501-$10,000	Balance $10,001-$15,000	Balance $15,001-$20,000	Balance $20,001-$30,000	Balance $30,001-$40,000	Balance $40,001-$50,000	Balance >$50,001
$25,000-$30,000	60%	50%	40%	30%	20%	10%	10%	10%	10%
$30,001-$40,000	70%	60%	50%	40%	30%	20%	20%	20%	15%
$40,001-$50,000	80%	70%	60%	50%	40%	30%	30%	30%	20%
$50,001-$75,000	90%	80%	70%	60%	50%	40%	40%	40%	30%
$75,001-$100,000	100%	85%	80%	70%	60%	50%	50%	50%	40%
$100,001-$150,000	100%	85%	80%	75%	70%	60%	60%	60%	50%
$150,001-$200,000	100%	90%	85%	80%	75%	70%	70%	70%	50%
> $201,000	100%	90%	85%	80%	80%	70%	70%	70%	50%

REQUIRED DOCUMENTATION:

To process the application we need proof of household income for the last 12 months.
We require income from 2019, as well as 2020 year to date. See below for acceptable documents.

A complete copy of 2019 Federal Tax Return.

If you do not file a tax return, we can accept items from the list below to support your 2019 income:

- W-2's
- Pension
- Social Security Retirement Benefit – yearly statement
- Social Security Disability Benefit – yearly statement
- Unemployment Compensation – begin/end dates
- Disability Compensation – begin/end dates
- Workers Compensation Benefit – begin/end dates
- Profit/Loss – if not shown on 2019 Federal Tax Return
- Child Support/Alimony – if not shown on 2019 Federal Tax Return

In addition, we need proof of income for 2020 – we will accept items from the list below:

- Most Recent Pay Stub – provide pay stub for all jobs held in 2020
- Pension
- Social Security Retirement Benefit – monthly statement
- Social Security Disability Benefit – monthly statement
- Unemployment Compensation – 1/1/20 to present
- Disability Compensation – 1/1/20 to present
- Workers Compensation Benefit – 1/1/20 to present
- Self Employed Income (P&L) – 1/1/20 to present
- Child Support/Alimony

Please see reverse for APPLICATION

15 Hospital Drive, York, ME 03909 | (207) 363-4321 | (877) 363-4321 toll free | (207) 363-7433 TTY | www.yorkhospital.com

HELP APPLICATION

January 1, 2020 through December 31, 2020

Please return this portion with your financial documents.

FOR OFFICE USE ONLY
Date:_____

PATIENT INFORMATION:

Last Name *First Name* *Middle Initial* *Social Security Number* *Date of Birth*

Street Address *City* *State* *Zip Code* *Length of time at address*

Mailing Address *City* *State* *Zip Code*

Home Phone Number *Work Phone Number* *Cell Phone Number*

PERSON FILLING OUT APPLICATION, IF DIFFERENT FROM PATIENT:

Last Name *First Name* *Middle Initial*

Street Address *City* *State* *Zip Code*

Mailing Address *City* *State* *Zip Code*

Home Phone Number *Work Phone Number* *Cell Phone Number*

PLEASE LIST BELOW PATIENT ACCOUNTS – consideration for HELP Program:

(if more than three Visit ID Numbers, list on separate sheet)

York Hospital Visit ID Number: _____ *Date of Service:* _____ *Amount Due:* _____

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I understand the information which I submit concerning my family's annual income is subject to verification by YORK HOSPITAL. I also understand that if the information which I submit is determined to be false, such a determination will result in the denial of financial assistance by YORK HOSPITAL, and I will be liable for charges of services provided.

I affirm the above to be true and correct

Applicant (please print): _____ Date:_____

Signature: _____ Date:_____