

FAP APPLICATION
January 1, 2022 to December 31, 2022



Applicant Information (Please print)

Last Name	First Name	Middle Name	DOB	SSN
Address		City/State/Zip Code		Phone
Mailing Address		City/State/Zip Code		Marital Status
Email address		Current Employer		Start Date

Spouse/Co-Applicant Information (Married or Registered Domestic Partners Only)

Last Name	First Name	Middle Name	DOB	SSN
Phone#	Employer			Start Date and Salary (yearly)

Dependents (All Applicants Under 18 Years of Age and Currently Residing with Applicant)

Name	DOB	Relationship	Insurance	Applying for FAP

Insurance (if none, indicate N/A)	Policy#	Effective Date
Is Insurance through the Market Place/Affordable Care Act?		

Document Requirement *

A Medicaid determination letter is required unless the applicant has insurance through the Market Place/Affordable Care Act.

A Maine resident is asked to apply for MaineCare and referred to our York Hospital Patient Navigator (207)351-2007 to assist you with this process. You may also apply by calling 1-800-442-6003 or visit <https://www.maine.gov/benefits/accounts/login.html>.

New Hampshire residents may apply for Medicaid at your local Department of Health and Human Services. You may also apply by calling 1-603-447-3841 or visit <https://nheasy.nh.gov>.

Savings and Investments

Checking account balance	
Savings account balance	
Investment balance(s)	
IRA/403B/401K balance	
Automobile year/make/model	
Recreational vehicle year/make/model	

For questions regarding this application, please contact us at (207) 351-2398 or (207)351-2389.

Mail to: York Hospital, Attention Financial Assistance Office, 15 Hospital Drive, York, Maine 03909

(OVER)

Household Income

Applicant and household must provide 2021 completed federal tax return, W-2, or other documents showing 2021 income. Applicant and household must also provide 2022 income, year to date. Please furnish the below documentation:

If Household Receives:	Amount per Month:	Applicant Must Provide:
Earnings/wages from employer(s)	\$	Year to date paystubs or pay detail report from each job showing gross income.
Self Employed	\$	Year to date profit and loss statement.
Rental Income	\$	Year to date statement of income
Unemployment, STD, LTD or workers' comp benefits	\$	Weekly claims report showing year to date gross income OR pay detail from employer showing disability payment.
Social Security or SSD	\$	2021 and 2022 benefit letters. To request a copy of your benefit letter, call 1-877-40S-1448 or visit www.ssa.gov. 1099 Form not accepted
Retirement or Pension Benefits	\$	Benefit letter or statement (401K, IRA, etc.) showing gross amount distributed.
General Assistance	\$	Current month General Assistance benefits letter.
No income for the last 3 months	\$	Request Self-Declaration letter from FAP office.
Alimony/Child Support	\$	Copy of court order, 12 months of cashed checks/receipts, or bank statement.
Dividends/Interest	\$	Quarterly dividend statements or 12 months bank statements.
Other	\$	Lottery winnings, non-wage earnings, cash for odd jobs, etc. for the last 12 months

Please list all monthly expenses that apply to applicant's household:

Expense:	Monthly Payment:	Expense:	Monthly Payment:	Expense:	Monthly Payment:
Housing (mortgage/rent)	\$	Cable/Internet	\$	Credit Cards	\$
Property Taxes	\$	Child Care	\$	Medical Bills	\$
Homeowners/ Renter's Insurance	\$	Personal/ Home Equity Loan	\$	Pet Costs	\$
Gas/Oil (Heat)	\$	401K/403B	\$	Internet	\$
Home/Cell Phone	\$	Auto Loan	\$	Food	\$
Electricity	\$	Auto Insurance	\$	Additional expenses	\$
Water/Sewer	\$	Gasoline for Auto	\$		

Please remember to include a copy of your proof of income documents.

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. I also understand that if any of the information which I submit is determined to be false, such determination will result in a denial of providing services as Financial Assistance, and that I will be liable for charges for services provided.

Applicant Signature _____

Date _____

Co-Applicant Signature _____

Date _____