www.bucksportrhc.org

Bucksport Regional **Health Center**

110 Broadway – Bucksport, ME 04416 ~ CLINICAL (207) 469-7371 ~ DENTAL (207) 902-1100
37 Commerce Park – Ellsworth, ME 04605 ~ CLINICAL (207) 667-5064

The Health Access Connection Program is a federally funded program designed to assist our patients with medical/dental expenses. The Health Access connection Program is based on income, family size and the patient responsibility is a percentage of Bucksport Regional Health Center's total charges billed. To ensure continued participation with the Health Access connection Program, Health Access Connection **payment must be collected at the time of each appointment**.

If you are interested in applying for the Health Access Connection Program, please complete the enclosed application and return to Bucksport Regional Health Center ~ 110 Broadway, Bucksport, Maine 04416. All information requested within the application is required in order for the application to be processed. If you qualify for the Health Access Connection Program, you will receive a letter of notification by mail from the Health Access connection Coordinator. If you qualify for the Health Access Connection Program, please note that not all dental services are covered.

This Application is for: (please check one)

- ☐ Medical
- ☐ Dental
- ☐ Both Medical & Dental

Bucksport Regional Health Center <u>MUST</u> have copies of all of the following documents in order to process your application.

- ☐ Completed Health Access Connection Application (Back Side of Document)
- ☐ Proof of Income (Include Pay Stubs, Social Security, Disability, Child Support, Etc.)
- ☐ Copy of _____ Federal Income Tax Return Form-1040 (Include Schedule C if Self-Employed)
- ☐ Copy of Most Recent Utility/Power Bill (For Address Confirmation)
- ☐ Verification of Assistance Received (Food Stamps, Fuel Assistance, Etc.)

<u>Please do not schedule an appointment with the Medical or Dental Center until your application is approved.</u>
If you have an emergency and need to make an appointment prior to the approval of your application, you will need to pay full cost at the time of service.

Note: For Applicants who are already patients, the Health Access Connection discounts will not take place for existing balances.

~PLEASE COMPLETE THE FOLLOWING APPLICATION ~

Bucksport Regional **Health Center**

HEALTH ACCESS CONNECTION APPLICATION

NAME			
(CURRENT) **MAILING ADDRESS**			
(CURRENT) **PHYSICAL ADDRESS**			
HOME PHONE NUMBER		**ALTERNATE CONTACT NUMBER**	

HOUSEHOLD INFORMATION (PLEASE LIST ALL MEMBERS OF HOUSEHOLD)

NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	DATE OF BIRTH	RELATIONSHIP (SELF, SPOUSE, CHILD, ETC.)	INCOME AMOUNT	SOURCE OF INCOME (JOB, SSI, TANF, ETC.)
			$ _____ PER _____	
			$ _____ PER _____	
			$ _____ PER _____	
			$ _____ PER _____	
			$ _____ PER _____	

PLEASE PROVIDE THE FOLLOWING DOCUMENTATION FOR REVIEW OF YOUR APPLICATION

☐ **PROOF OF INCOME** ☐ **COPY OF DRIVER'S LICENSE** ☐ **RECENT COPY OF POWER BILL** ☐ **LAST YEAR's TAXES**

***WHEN APPLICABLE, PLEASE PROVIDE PROOF OF INCOME FOR EACH HOUSEHOLD MEMBER.**
FAILURE TO PROVIDE PROOF OF INCOME WILL DELAY THE REVIEW OF YOUR APPLICATION.

ZERO INCOME (PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME)

NAME OF LAST EMPLOYER		**DATE OF LAST EMPLOYMENT**	

PLEASE EXPLAIN HOW YOUR BASIC NEEDS HAVE BEEN MET

FOOD	
SHELTER	
UTILITIES	
NON-FOOD ITEMS (CLOTHING, ETC.)	

I, _____, CERTIFY THAT I HAVE HAD NO SOURCE OF INCOME SINCE _____.
Name *Date*

DO YOU HAVE INSURANCE? ☐ YES ☐ NO				**DO YOU QUALIFY FOR ANY OF THE FOLLOWING?**	
☐ AETNA	☐ ANTHEM	☐ CIGNA	☐ MCHO	☐ FOOD STAMPS	☐ FUEL ASSISTANCE
☐ MAINECARE	☐ MEDICARE	☐ MARTIN'S POINT	☐ UNITED HEALTH	☐ LOW COST DRUG ASSISTANCE	☐ HOUSING ASSISTANCE

I certify that my income (including everyone listed above with income from ANY source) is $_____ monthly. I understand that because of the above information I am now presenting, I and members of my household may be entitled to receive Federal benefits. **My signature below also gives authorization to the Bucksport Regional Health Center officials to verify this information and that the intentional misrepresentation may mean prosecution under applicable State and Federal laws.**

_____ _____
Signature of Adult **Date**
MUST BE SIGNED BY THE APPLICANT

~ OFFICE USE ONLY ~

DATE APPLICATION RECEIVED: _____ **DATE ENTERED IN COMPUTER:** _____

RECOMMENDED HAC	EFFECTIVE DATE FROM	EFFECTIVE DATE TO	RENEWAL	
			☐ 30 DAY ☐ 60 DAY ☐ 90 DAY	☐ 180 DAYS ☐ 1 YEAR

_____ _____
Signature - Health Access Coordinator **Date**

_____ _____
Signature - Executive Director **Date**

10-9-19TLH