Application for ACCESS TO CARE

(Please Print)

Pines Health Services
PO Box 40
Caribou, ME 04736
(207) 498-1371 or (207) 498-1617

1) Patient/Applicant		
A) Demographics	**B) If employed?**	**C) If not employed?**
Name:	**Employer Name:**	**Last Date Worked:**
SSN: **DOB:**	**Job Title:**	**Please explain:**
Cell/Home Phone:	**Work Phone #:**	
Address:	**Address:**	
Marital Status:	**Hire Date:**	(office use) MR #:

2) Significant Other/Co-applicant		
A) Demographics	**B) If employed?**	**C) If not employed?**
Name:	**Employer Name:**	**Last Date Worked:**
SSN: **DOB:**	**Job Title:**	**Please explain:**
Cell/Home Phone:	**Work Phone #:**	
Address:	**Address:**	
Marital Status:	**Hire Date:**	(office use) MR #:

3) Dependents						
	Last Name	**First Name**	**Middle Initial**	**Relationship**	**Date of Birth**	(office use) MR #:
1						
2						
3						
4						

4) Gross Household Income		
	Prior 3 Months	**Prior 12 Months**
Wages and Salaries		
Self-Employment Income		
Social Security		
Unemployment		
Worker's Compensation		
Alimony/Child Support		
Dividends/Interest/Rental		
Other:_____		
_____		
Totals:		

5) Mainecare

Have you applied for Medical Coverage through the Department of Health and Human Services?

YES:_____ NO:_____

If yes, what date did you apply?

_____

Do you have any existing health insurance coverage?

YES:_____ NO:_____

If you do not currently have health coverage, a denial of coverage for Mainecare from Department of Health and Human Services (DHHS) will be required before this application can be processed. If you do have a current denial letter, please attach a copy.

If household income changes, a new Applicaton must be submitted. **Not all services are covered under our ACCESS TO CARE program.** For questions, please contact our Financial Counselors at (207) 498-1371, 498-1617, (800) 858-2279 ext 1371 or 1617, or email billinghelp@pineshealth.org.

I hereby attest that the above information is true and accurate to the best of my knowledge and give my consent to verify any of the above information. I acknowledge that any false information provided may revoke Access-to-Care eligibilty, at the discretion of Pines Health Services.

_____ _____ _____ _____

Applicant's Signature Date Co-applicant's Signature Date

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FOR OFFICE USE ONLY

Application: Approved ____ Denied ____ Deferred ____ Date of Decision:_____

Yearly Income:_____ Income Guidelines:_____ Approval Signature:_____

Over Income:_____ Under Income:_____ Date:_____

Please return application and supporting documentation to: Cary/Pines Business office, 163 Van Buren Rd, Suite 1, Caribou, ME 04736.