

HRCHC Affordable Care Application

A) Your information: (Applicant)

Name:

Phone:

Address:

City/ State/ Zip

B) LIST YOURSELF AND FAMILY/HOUSEHOLD MEMBERS

Name	DOB	Has Medicaid	Relationship	Zero Income	Applying for Affordable care
1.		Y N		Y N	Y N
2.		Y N		Y N	Y N
3.		Y N		Y N	Y N
4.		Y N		Y N	Y N
5.		Y N		Y N	Y N
6.		Y N		Y N	Y N
7.		Y N		Y N	Y N

NOTE: If one or more of the household members are over 21 and not the primary applicant or spouse, proof of full time student status must be provided, such as a school transcript or acceptance letter.

PROOF OF INCOME(choose one of the following)

1) **EMPLOYED:**

- The first two (2) pages of your most recent Federal Income Tax return, or
- W-2 form, or
- Recent two (2) consecutive pay stubs, or
- A letter from employer with address and phone number of employer, stating that you are an employee and the gross weekly income paid to you

Important note: Please send average pay stubs. If you are a seasonal worker, please note average weeks worked so that your income can be adjusted accordingly.

2) **SELF-EMPLOYED:**

- First two pages of 1040 and First two pages of Schedule C of your recent Federal Income Tax return

3) **UNEMPLOYED:**

- Notice of benefit amount from Department of Labor

4) **OTHER:** (Choose all that apply)

- Social Security: Recent social security notice or copy of bank statement showing direct deposit.
- Pensions: Copy of recent checks
- Child Support/Alimony: Copy of legal document or recent check payable.
- TANF – (AFDC) Copy of recent check/ check stub
- Interest on Savings/Earnings
- Disability benefit notice
- Worker’s compensation notice
- Widows benefit income notice
- Other income from miscellaneous sources

5) **NO INCOME:**

- Signed letter from a family member or friend stating that you have no source of income, and that the family member or friend is providing financial support to you and your family.

Note: If you have custody of minor children and are receiving child support you must include this amount under income.

<u>PENALTIES FOR MISREPRESENTATION:</u> I certify that all of the information is true and correct and that all income is reported. I understand that this information is being provided for the receipt of Federal funds; that institution officials may verify the information on the statement and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.	
X _____ Applicant’s Signature (or advocate)	_____ Date:

For office use only: (ACC initials) _____ **Date:** _____

Common Questions and Answers about Affordable Care

1) How soon will a decision be made?

- Your application will be processed within five (5) working days.
- The 1st day of the month the application is received will be the effective date.
- If your income or family size does not change, the Affordable Care amount is good for twelve (12) months.
- The Affordable Care program will notify you by mail when it is time to renew your application.

2) What is my responsibility?

- It is your responsibility to notify us immediately in writing if your income or family size changes within the twelve month period.
- It is your responsibility to notify us as soon as possible of any address changes.

3) What does the Affordable Care Program Cover?

- Visits to the Health Center
- Supplies used at Health Center visits
- If you are hospitalized, hospital visits by the Health Center Doctor
- Lab tests performed and lab specimens collected at the Health Center, however you will receive bills from any outside labs.

Bring this form to your health center with:

- Signature
- Proof of Income, or
- Proof of no income

Or mail it to:

HealthReach Community Health Centers
Attn: Angela Blanchard
PO Box 727
Waterville, ME 04903-0727

Telephone: (207) 861-3416
Toll Free: 1-800-299-2460

Your Fees Will Be Reduced if:		
Your family size is		and your family's income is less than:
1		\$22,341
2		\$30,261
3		\$38,181
4		\$46,101
5		\$54,021
6		\$61,941
7		\$69,861
8		\$77,781

If you would like help applying for Maine Care or other programs such as Care Partners or the Breast and Cervical Health Program circle **YES**