Houlton Regional Hospital
20 Hartford Street
Houlton, Maine 04730
207-521-2619

Application for Free Care Program and Sliding Fee for Rural Health Centers

Applicant Name:_____
(Last Name) (First Name) (Middle initial)

Applicant Address:_____
(Street Address) (City) (State) (Zip)

Date of Birth:_____ Social Security #:_____ Home Phone #:_____

Employer Name:_____ Address:_____

Spouse's Name:_____
(Last Name) (First Name) (Middle initial)

Date of Birth:_____ Social Security #:_____

Employer Name:_____ Address:_____

Dependent's Name:_____ Age:_____ Relationship:_____

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Dependent's Name:_____ Age:_____ Relationship:_____

Dependent's Name:_____ Age:_____ Relationship:_____

For internal use only:
Application date:_____ Expiration date:_____

Notified: Patient ____ ACSA ____ MRI ____ RAD ____ RHC SLIDING SCALE % ____

Application continued on reverse.

FAMILY MEMBER	***SOURCE OF INCOME*** *(i.e. employment, social security, unemployment comp, child support, pensions etc.)*	***AMOUNT OF GROSS INCOME FOR THE LAST 13 WEEKS***	***EST. YEARLY INCOME*** (office use only)

Please provide proof of income for the most current 13 weeks. *If you are self-employed, you will be required to provide a copy of your last income tax return and your most current quarterly report of income (1099). If you have not filed a 1099, personal records of income will be required.*

I certify that this information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (MCD, HCR or other insurance plan) which may be available for payment of my hospital charges and I will take any action reasonably necessary to obtain the assistance. All payments will be assigned to the hospital to recover the hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature:_____ Date:_____

HOULTON REGIONAL HOSPITAL
EXCEPTIONAL CARE. COMPASSIONATE PEOPLE.

Free Care Program

Date:_____

For the purpose of applying for the Free Care program, I,

_____

(Applicant's Name)

certify that I have not received any income for the last thirteen (13) weeks.

Briefly explain how you have managed to pay for necessary living expenses such as: shelter, food, and utilities:

_____

_____

_____

_____

_____

Please sign this document before a Notary Public.

Signature:_____ Date:_____

State of Maine
_____, ss.

Personally appeared before me the above-named _____and made oath that the above-stated facts are true to the best of his/her knowledge.

Date: _____ _____
Notary Public