HOULTON REGIONAL HOSPITAL
EXCEPTIONAL CARE. COMPASSIONATE PEOPLE.

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

## Application for Financial Assistance and Sliding Scale Programs for the Hospital and related Rural Health Centers

Applicant Name:______________________________________________
*(Last Name) (First Name) (Middle initial)*

Applicant Address:____________________________________________
*(Street Address) (City) (State) (Zip)*

Date of Birth:______________Social Security #:___________________(optional)

Home Phone #:_____________________

Employer Name:____________________________Address:____________________________

Spouse's Name:______________________________________________
*(Last Name) (First Name) (Middle initial)*

Date of Birth:________________Social Security #:___________________(optional)

Employer Name:____________________________Address:____________________________

Dependent's Name:___________________________Age:_______Relationship:___________

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Dependent's Name:___________________________Age:_______Relationship:___________

Dependent's Name:___________________________Age:_______Relationship:___________

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) |
|---|---|---|---|
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***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:___________________________________

*For internal use only*:
Application date:______________________________ Expiration date:_____________________________

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

# Financial Assistance Program

Date:____________________

For the purpose of applying for Financial Assistance, 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