HOULTON REGIONAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

Application is for: ☐ Financial Assistance ☐ Sliding Fee Scale ☐ Both

SECTION ONE: PATIENT INFORMATION

Name		Address
Phone Number	Date of Birth	
Email	# of Dependents	Marital Status (Optional)
Current Health Insurance		Occupation

SECTION TWO: INCOME INFORMATION

Please provide your most recent tax return or pay stubs for the previous three (3) months.

Income Source	Applicant	Spouse
Wages / Self Employment		
Social Security		
Unemployment		
Pension		
Rental Income		
Other Taxable Income		

SECTION THREE: HOUSEHOLD INFORMATION

Name	Age	Relationship

SECTION FOUR: CERTIFICATION

I certify that the information provided is true and accurate to the best of my knowledge. I understand that Houlton Regional Hospital may verify this information and that providing false or misleading information may result in denial or revocation of financial assistance, may make me financially responsible for services received, and may violate applicable law.

Signature _____ Date _____

HOULTON REGIONAL HOSPITAL

ZERO INCOME AFFIDAVIT

This affidavit may be used in place of traditional income documentation when acceptable proof of income is unavailable. Houlton Regional Hospital reserves the right to request additional information or documentation if needed to determine eligibility.

APPLICANT INFORMATION

Name		Address	
Phone Number	Date of Birth		
Email		# of Dependents	Marital Status (Optional)
Current Health Insurance		Occupation	

CURRENT FINANCIAL SUPPORT

Please briefly explain how you are meeting your basic living expenses (housing, food, utilities, transportation, etc.).

CERTIFICATION (please initial)

_____ I am requesting financial assistance based on my current financial circumstances.

_____ I certify that I currently have no source of income, including wages, self-employment, unemployment benefits, Social Security, pensions, retirement income, rental income, public assistance, or other taxable income.

_____ I certify that the information provided is true and complete to the best of my knowledge.

_____ I understand Houlton Regional Hospital may verify the information provided and request additional documentation.

_____ I understand that providing false or misleading information may result in denial or revocation of financial assistance and that I remain financially responsible for services received.

_____ _____

Signature Date