



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: _____

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

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

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: _____



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