



Free Care Application Form Instructions

Thank you for requesting an application for the free care program. There are a few things we must have before a determination can be made. You must be a Maine resident to apply for free care. Out-of-state residents will be considered for emergency and urgent care situations only.

We must have proof of all sources of income as follows:

- **Household Income:** All members of the household must be included on the application along with their proof of income. (*Note: If anyone else can claim you as a dependent, that person must be included on the application along with their proof of income.*)
- **If you are actively employed or self employed,** please attach the following documentation to your financial application:
 - Confirmation of income earned in the **last 3 months**; such as pay stubs.
 - Confirmation of your **annual income**; W-2's, or most recent tax return.
- **If you are receiving Social Security,** pensions or other forms of retirement income we must have a copy of the check received or a bank statement showing the deposits made.
- **If you are living on savings accounts or investments** we need two consecutive months' statements to show that you are spending those funds to meet daily expenses.
- **If you are unemployed** and not receiving any income we need a letter of support written by the person supplying your day-to-day needs.
- **If you are receiving unemployment benefits** we must have a copy of the check or determination letter.

It may be necessary for you to apply for MaineCare. If you answer yes to any of the following questions, please contact your local DHS office and request an application for MaineCare.

- Are there children under the age of 18 in the home?
- Are you in a pregnancy status?
- Are you disabled or feel that you will be unable to work for 12 months?
- Are you under 21 or over 64?

If you have already applied for MaineCare, please include a copy of their determination letter.

If you fail to provide the requested information your application will be returned. Additionally, please make sure you sign and date the application or it will be returned.

If you need assistance in completing the form, please feel free to call us. Please refer to the first letter of your last name when choosing the appropriate extension below to call for assistance.

(A-C) 768-4261; (D-H) 768-4262; (I-N) 768-4263; (O-Z) 768-4591



Eastern Maine Healthcare Systems
Application for Financial Assistance
 - For Medically Necessary Services Only -

Where did patient receive medical care?
 The Aroostook Medical Center

Patient Name: Last First Middle Init MR# (office use)

Applicant Name: Last First Middle Init MR# (office use)

Mailing Address		Employer Name and Address		Job title:	- - - SSN	Marital Status
_____	Home phone _____	_____	Work phone _____	Start Date: _____		
City State Zip	Cell Phone _____	City State Zip			DOB _____	

Spouse/Co-Applicant Name: Last First Middle Init MR# (office use)

Mailing Address		Employer Name and Address		Job title:	- - - SSN	Marital Status
_____	Home phone _____	_____	Work phone _____	Start Date: _____		
City State Zip	Cell Phone _____	City State Zip			DOB _____	

CHILDREN or DEPENDANTS							
Last	First	Middle Initial	Relationship	Date of Birth	In Household?	Claimed on taxes?	MR# (office use)

GROSS INCOME		ASSETS	
Applicant	Co-Applicant		
Weekly Salary		Cash	Balance:
Dividends / Interest		Checking Account	Balance:
Gross Rental Income		Savings Account	Balance:
Business / Self - Employment		Life Insurance	Cash Value:
Social Security		Annuities	Balance:
Social Security Disability		Stocks / Bonds	Market Value:
Workers Compensation		Real Estate	Years owned:
Military / Pension		Other Real Estate	Years owned:
Unemployment Compensation		Automobiles	Year / Make:
Alimony / Child Support		Other Vehicles	Year / Make:
Other Income:		Business Equipment	Balance/Value:
ATTACH DOCUMENTATION	TOTALS	Other Assets:	

MONTHLY EXPENSES/LIABILITIES	Monthly Payments	Balance Due	MAINECARE COVERAGE: Have you applied for Medical Health Coverage through the Department of Human Services? YES or NO (circle one) If YES, what date did you apply? _____ NOTE: If you do not currently have coverage, a denial of coverage for MaineCare from the Department of Health and Human Services may be required before this application can be processed. OTHER INSURANCE COVERAGE: Does anyone listed on the application currently have insurance? YES or NO (circle one) IF YES, ATTACH COPY OF CARD
Rent / Mortgage			
Other Mortgages			
Loans			
Charge Accounts			
Prescription Medication			
Electricity, Water, Telephone, Groceries			
Other			
TOTALS			

SIGN HERE **Applicant** _____ **SIGN HERE** **Co-Applicant** _____

I/We certify that all the information given is true and complete. I/We give permission to Eastern Maine Healthcare Systems to verify any facts pertaining to the provided information. **PLEASE ATTACH ANY ADDITIONAL DOCUMENTATION THAT EXPLAINS YOUR FINANCIAL SITUATION**



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OFFICE USE ONLY:
 Medical Record Number/s:

THIS SECTION FOR OFFICE USE ONLY - DO NOT COMPLETE

Total Annual Gross Income _____ Number of Dependents: _____

APPROVAL _____
 Level: **1** **2** **3** (Circle one)
 Percentage _____
 Total Write off _____
 Other comments: _____

DENIAL _____
 Denial Reason: (Circle all that apply)
POI **Over income** **Missing Signature/s**
LOS **Over asset** **MaineCare non-compliance**
 Other: _____

INDICATE INCOME CALCULATION USED:
 3 MONTHS or 12 MONTHS (Circle One). If OTHER, detail here:

_____	_____
<i>Processor Signature</i>	<i>Date</i>
_____	_____
<i>Manager Signature</i>	<i>Date</i>
_____	_____
<i>VP Signature</i>	<i>Date</i>