APPLICATION FOR FREE CARE AND PARTIAL FREE CARE
Central Maine Medical Center/Family Practice Residency Program/ Bridgton Hospital / Rumford Hospital

Expiration Date: ____________ Guarantor #: ______________

Guarantor Name: ____
(Last Name) *(First Name)* *(Middle initial)*
Guarantor 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: ______________

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 or your accountant's records will be required. Without this information, Free Care cannot be granted.

ADDITIONAL INFORMATION FOR CMMF FREE CARE
ASSETS AND LIABILITIES

ASSETS	***LIABILITIES***
Cash on Hand:	Rent/Mortgage:
Checking Account Balance: ________________ Name of Bank: ____________________________	Auto Loans:
Savings Account Balance: __________________ Name of Bank: ____________________________	Other Loans:
Equity of Real Estate Owned:	Visa/MasterCard:
Vehicles Owned: Make __________ Year Make __________Year	Other Cards:
Other Assets:	Utilities:
Total Assets:	**Total Liabilities:**

I certify that all of the above statements are true and complete. Authorization is hereby given to Central Maine Medical Family to verify in any manner it deems appropriate any items indicated on this statement.

Applicant's Signature:________________________________Date:_________________________________

Approved:____Date: ________ ME_____CMMF Level 1___

CMMF Level 2___

Please return this application in the envelope provided or to the following address:

Central Maine Medical Family
Patient Financial Services
P.O. Box 4100
Lewiston, Maine 04243-410

Maine Free Care Program

Date: _________________

For the purpose of applying for the Maine 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:

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Please sign this document before a Notary Public.

Signature: ____ Date: __________

Notary: ____ Date: __________

Print name _________________________________

Commission Expires on _______________________