



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

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: _____

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

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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 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 _____

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:

Please sign this document before a Notary Public.

Signature: _____ Date: _____

Notary: _____ Date: _____

Print name _____

Commission Expires on _____