Eastern Maine Healthcare Systems

Application for Free Care

For Medically Necessary Services Only

1. FACILITY WHERE MEMBERS OF YOUR HOUSEHOLD RECEIVES CARE:	☐EMMC ☐Acadia ☐CADEAN ☐BHMH ☐INLAND ☐TAMC ☐SVH

2. PATIENT/APPLICANT	EMPLOYMENT INFORMATION	NOT EMPLOYED?
NAME:	EMPLOYER NAME:	LAST DATE WORKED:
SSN: DOB:	HIRE DATE:	
CELL/HOME PHONE:	JOB TITLE:	PLEASE EXPLAIN:
ADDRESS:	PHONE:	
	ADDRESS:	
MARITAL STATUS:		(Office Use) MR#:

3. SIGNIFICANT OTHER/CO-APPLICANT	EMPLOYMENT INFORMATION	NOT EMPLOYED?
NAME:	EMPLOYER NAME:	LAST DATE WORKED:
SSN: DOB:	HIRE DATE:	
CELL/HOME PHONE:	JOB TITLE:	PLEASE EXPLAIN:
ADDRESS:	PHONE:	
	ADDRESS:	
MARITAL STATUS:		(Office Use) MR#:

4. DEPENDANTS IN THE HOUSEHOLD	RELATIONSHIP	DATE OF BIRTH	√ IF IN HOUSEHOLD	√ IF CLAIMED ON TAXES	(Office Use) MR#

5. GROSS HOUSEHOLD MONTHLY INCOME	APPLICANT	CO-APPLICANT	6. HOUSEHOLD ASSETS	
WAGES & SALARIES			CASH	
DIVIDENDS / INTEREST / RENTAL INCOME			CHECKING ACCOUNT	
SHORT/LONG TERM DISABILITY			SAVINGS ACCOUNT	
BUSINESS/SELF-EMPLOYMENT			LIFE INSURANCE VALUE	
SOCIAL SECURITY INCOME/RETIREMENT			ANNUITIES BALANCE	
SOCIAL SECURITY DISABILITY (SSDI)			STOCKS & BONDS VALUE	
WORKERS COMPENSATION			PROPERTY–YEARS OWNED	
MILITARY / PENSION			VEHICLES (YEAR/MAKE)	
UNEMPLOYMENT BENEFITS			OTHER VEHICLES VALUE	
ALIMONY / CHILD SUPPORT			BUSINESS EQUIP VALUE	
OTHER INCOME:			OTHER ASSETS:	
TOTALS	$	$	**TOTALS**	$

7. MONTHLY EXPENSES/LIABILITIES	MONTHLY PAYMENTS	BALANCE DUE
RENT / MORTGAGE PAYMENT		
OTHER MORTGAGE PAYMENTS		
PERSONAL OR STUDENT LOANS		
CHARGE ACCOUNTS		
PRESCRIPTIONS, MEDICAL BILLS		
ELECTRICITY, WATER, PHONE, GROCERIES		
OTHER EXPENSES:		
TOTALS		

8. INSURANCE INFORMATION

HAS ANYONE IN THE HOUSEHOLD APPLIED FOR MAINECARE IN THE PAST 3 MONTHS? _____

IF YES: ATTACH COPY OF DETERMINATION LETTER

DOES ANYONE IN THE HOUSEHOLD HAVE INSURANCE? _____

IF YES: ATTACH COPY OF CARD/S

9. SIGNATURES

Sign Here

PATIENT/APPLICANT ***DATE*** ***CO-APPLICANT*** ***DATE***

I/We certify that all the information provided is true and complete.