Patient Financial Services

# Request for Determination of Eligibility for Free Care



Maine Behavioral Healthcare

| PATIENT NAME | | DATE OF BIRTH | SOCIAL SECURITY # |
|---|---|---|---|
| ADDRESS | | | |
| PHONE NUMBER | | DATE OF SERVICE / ACCOUNT # | |
| RESPONSIBLE PARTY | ADDRESS | | SOCIAL SECURITY # |
| ADDRESS | | | |
| MARITAL STATUS | INSURANCE NAME, IF ANY | | |
| EMPLOYER | OCCUPATION | | RATE OF PAY |

SIZE OF FAMILY:_____

| NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Income:** *(List all income for yourself, spouse and other dependents, from any of the following:)*

| | Total for Last 3 Months | Total for Last 12 Months |
|---|---|---|
| Wages | $_____ | $_____ |
| Self-Employment | $_____ | $_____ |
| Social Security | $_____ | $_____ |
| Unemployment | $_____ | $_____ |
| Workers Comp | $_____ | $_____ |
| Alimony | $_____ | $_____ |
| Child Support | $_____ | $_____ |
| Pensions | $_____ | $_____ |
| Rental Prop Income | $_____ | $_____ |
| Dividends & Interest | $_____ | $_____ |
| Public Assistance | $_____ | $_____ |
| Other | $_____ | $_____ |

Continued ➔

**Proof of income is required. Please provide the following:**



_____: If self-employed, three month Profit and Loss statement and most recent tax return

_____: Income Tax Forms, valid January Through April **only**

_____: 4 most recent pay stubs, including year-to-date totals from all employers

_____: Written explanation of current financial situation - Notarized

_____: Denial notice from the Department of Human Services

_____: or other proof of your income

I affirm that the given information, including income, is true and correct to the best of my knowledge. I understand that the information which I submit concerning my annual income and family size is subject to verification by Maine Behavioral Healthcare. I also understand that if the information which I submit is determined to be false, such determination will result in a denial of providing services as Free Care, and that I will be liable for charges for services provided.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Person Making Request | Relationship to Patient | Date of Request |

**For patients completing this application to justify lower monthly payments, please include the following information related to expenses.**

**Monthly Expenses:** List all monthly expenses that apply.

| | |
|---|---|
| Housing (mortgage/rent): | $_____ |
| Property Taxes: | $_____ |
| Credit Cards/Loans: | $_____ |
| Auto Loans: | $_____ |
| Phone: | $_____ |
| Electricity: | $_____ |
| Water / Sewer | $_____ |
| Child Care: | $_____ |
| Fuel: | $_____ |
| Health Insurance: | $_____ |
| Insurance: | $_____ |
| Food: | $_____ |
| Other: | $_____ |

| | | |
|---|---|---|
| **Send completed form to:** | **Maine Behavioral Healthcare**<br>**Patient Financial Services**<br>**123 Andover Road,**<br>Westbrook, Maine 04092 | (207) 661-6658 or<br>Toll Free (888) 524-0080 |

| _____ | _____ |
|---|---|
| Financial Counselor | Date |
| _____ | _____ |
| Approving Signature | Date |