Mount Desert Island Hospital Free Care/Reduced Cost Application

Applicant(s) Name(s):		**Telephone Number:**	
Last Name:	***First Name:***	***Date of Birth:***	***Social Security Number***
ADDRESS	**CITY**	**STATE**	**ZIP CODE**

Please list additional members in household	**Relationship**	**Date of Birth**	**Claimed on Taxes?**

GROSS INCOME	**HOUSEHOLD**	**ASSETS**	
Weekly Salary		Checking Account Balance	
Dividends/Interest		Savings Account Balance	
Gross Rental Income		Real Estate	
Self-Employment		Automobiles	
Social Security/Disability		Life Insurance	
Workers Compensation		Other Vehicles, etc.	
Unemployment		**MAINECARE COVERAGE**	
Alimony/Child Support		Have you applied for MaineCare? _____YES _____NO (check one) • If you answered YES, please provide the MaineCare decision letter. • If you answered NO, and do not have healthcare insurance, please apply for MaineCare.	
Other Income			
ATTACH DOCUMENTATION FOR ALL ENTRIES ABOVE	Total: $		

I/We certify that all the information given is true and complete. I/We give permission to Mount Desert Island Hospital to verify any facts pertaining to the provided information. PLEASE ATTACH ANY ADDITIONAL DOCUMENTATION THAT EXPLAINS YOUR FINANCIAL SITUATION.

Please Sign Here:	Date: