Waldo County Healthcare, Inc. And Affiliates
118 Northport Avenue, PO Box 287
Belfast, Maine 04915

FINANCIAL APPLICATION

Part I. *Applicant Information*

Name: ____Date: ________________

I am requesting consideration for reduced installment payments or free care from Waldo County Healthcare, Inc. for the following debts.

Facility	Patient Account Numbers	Total Outstanding Amount
Waldo County General Hospital		
Waldo County Home Health Services		
Coastal Medical Care		
Belfast Public Health Nursing Association		
Arthur Jewell Community Health Center		
Stockton Springs Regional Health Center		
Donald S. Walker Health Center		
Searsport Health Center		

Applicant Social Security #__________________________Date of Birth________________

Applicant Address____

Telephone #: Days________________________ Evenings___________________________

Applicant Occupation______________________________Weekly Gross Pay____________

Applicant Employer Name & Address____

____Telephone #__________________

Spouse Name____________________________________Date of Birth_________________

Spouse Occupation_________________________________Weekly Gross Pay____________

Spouse Employer Name & Address____

____Telephone #__________________

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Part II. *Financial Information*

Check all of those that apply and **attach** to this application (*processing of your application will be delayed until this information is received):*

[ ] 3 most recent pay check stubs
[ ] most recent pension check stub
[ ] most recent social security check stub
[ ] copy of most recent federal income tax return

Fill out the following income and expense information including all members of your household.
All Financial Information needs to be completed or the application will be returned.

Monthly Gross Income		**Monthly Expenses**	
Description	**$**	**Description**	**$**
Wages		Mortgage/Rent	
Self Employment/Farm		Heat	
Rent		Electricity	
AFDC		Water & Sewer	
Social Security		Telephone	
Unemployment Comp.		Food	
Workers' Compensation		Clothing	
SSI		Vehicle payments	
Alimony		Insurance	
Child Support		Other:	
Military Family Allowance			
Pensions			
Dividends			
Interest			

ASSETS

BANK ACCOUNTS		
Financial Institution	**Type of Account (checking/savings,etc)**	**Balance**
1.		
2.		
3.		
4.		

VEHICLES	
Make/Model/Year	**Value**
1.	
2.	
3.	

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HOME	
Year Built	**Value**
OTHER ASSETS	

DEBTS

Type of Debt	Financial Institution	Balance Due	Monthly Payment
Mortgage			
Bank Loan			
Bank Loan			
Vehicle Loan			
Vehicle Loan			
Credit Card			
Credit Card			
Credit Card			
Other			
Other			

Part III. *Family Information*

Family Size (include anyone claimed as a legal dependent)		
Name	**Age**	**Relationship**
1.		
2.		
3.		
4.		
5.		
6.		

Is Applicant disabled? Yes [ ] No [ ]

Is Applicant covered by health insurance? Yes [ ] No [ ]

If Yes: Medicare #____________________________ Medicaid #__________________________
Blue Cross #___________________________ Commercial # ________________________
Other: Name___________________________ Policy #_____________________________

I have applied for other assistance. Yes [ ] No [ ]
If yes, indicate where:____
Approved [ ] Denied [ ]

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Part IV. A*greement*

The above statements are true and completely disclose my family's income, expenses, assets, and debts. I hereby authorize Waldo County Healthcare, Inc. and its employees or agents to verify the information included on this application by contacting any of the individuals or institutions listed on this application or included on any attachments.

Applicant Signature _________________________________ Date ______________________

Applicant Name (Printed)_____________________________

If there is someone who knows your financial situation who you would like us to contact to help determine your eligibility, complete the following.

Name ______________________________________Relationship _______________________

Address ___________________________________ Telephone _________________________

Attach any additional information that may help us in our decision. Submit the completed application and attachments to Waldo County General Hospital, Attn: Patient Accounting, PO Box 287, Belfast, Maine 04915, or deliver it to our Customer Service desk in the Patient Accounting department. Only completed applications will be processed. All information will be kept confidential.

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Part V. *For WCGH Patient Accounting Use Only*

Applicants Name: ____

Date of Birth: ____

Date Received ________________ Received By ______________________________

APPROVED [ ]

Approved for account #(s):____

Approved for dates of service from: ______________________ to: ______________________

DENIED [ ]

Denied because: ____

Signature ____ Date ______________________

Transaction Code Distribution:

W175 Charity Care – WCGH (over 150% income) ___________________________
W176 Charity Care – DHSS (up to 150% income) ___________________________

Z175 Charity Care – WCGH (over 150% income) ___________________________
Z176 Charity Care – DHSS (up to 150% income) ___________________________