Mid Coast Mental Health Center

12 Union St, Rockland, ME 04841 Telephone 207-701-4400

A Request for Determination of Eligibility for Reduced Fee Care

Date of Request:_____

I hereby request a written determination of my eligibility for Reduced Fee Care at Mid-Coast Mental Health Center. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by Mid Coast Mental Health Center. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as Reduced Fee Care and that I will be liable for charges for service provided.

1. NAME_____
   First Middle Last

   ADDRESS:_____
   Number and Street City State Zip Code

   TELEPHONE NO.:_____ DATE OF BIRTH:_____

2. CLIENT OCCUPATION:_____INCOME PER WEEK:_____

   CLIENT EMPLOYER:_____

   SPOUSE OCCUPATION:_____INCOME PER WEEK:_____

   SPOUSE EMPLOYER:_____

3. INCOME: List income for all family members from:

	Last 3 Months	Last 12 Months
Wages----------	_____	_____
Self employment----------	_____	_____
Social Security----------	_____	_____
Unemployment Compensation----------	_____	_____
Worker's Compensation----------	_____	_____
Alimony----------	_____	_____
Child Support----------	_____	_____
Pension----------	_____	_____
Income from Dividends, Interest, Rent--------	_____	_____

4. Family:

Name	Date of Birth	Relationship
_____		
_____		
_____		

I affirm that the following information is true and correct to the best of my knowledge

_____ _____
Date Signature (person making request)

_____ _____
Date of Determination Signature (person making determination)