Exhibit B

Greater Baltimore Medical Center
Patient Financial Services
PO Box 310
Lutherville, MD 21094-0310

Due back on or before: _____

PATIENT INFORMATION SHEET AND FULLFILLMENT REQUIREMENTS

Thank you for inquiring about our Financial Assistance Program. Everyone is eligible to apply. The Financial Assistance Application you have been given will need to be completed and returned to us.

Please provide any of the following information that applies to your situation:

- 2 recent pay stubs for each family member 18 years or older, including date of hire **Please note your status on your pay stubs (full time, part time, number of hours per week) Please also note how you are paid (weekly, bi-weekly or bi-monthly)**
- 2 most recent unemployment insurance pay stubs
- A copy of your most recent income tax returns **(Federal and State) with W2's (all pages)**
- A copy of your current Social Security Award Letter
- A copy of your Medical Assistance/Food Stamps or Cash Assistance denial or approval letter
- A complete copy of your 2 most recent checking and savings account statements **(all pages) Bank statements must include account holder name(s), account number(s) and daily balance(s)**
- A copy of your 2 most recent investment statements (Money Market, CD, Stocks etc.)
- A letter of hardship, briefly explaining your need for financial assistance
- If you do not have any income, a notarized letter from the person providing your support is required - depending upon the situation additional information may be requested
- Proof of social program eligibility, i.e. SNAP, WIC, etc.

Failure to return the above information that is applicable to your situation may prevent us from considering your Financial Assistance application. Please explain in your letter of hardship your reason for not supplying any of the above information.

The attached "Medical Assistance Screening Check List" also needs to be completed. This document helps us to determine if you may be eligible for additional programs. Please make sure you sign and date your application; and return your application to the address shown above.

Representatives are available Monday through Friday, from 8:00 AM to 4:30 PM. Please feel free to contact us at (443) 849-2450 or at (800) 626-7766. **We look forward to assisting you with your application process.**

Sincerely,

The Patient Financial Services Department

Exhibit C

Maryland State Uniform Financial Assistance Application

Information About You

Name: _____
First *Middle Initial* *Last*

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐ Marital Status: ☐ Single ☐ Married ☐ Separated

US Citizen: ☐ Yes ☐ No Permanent Resident: ☐ Yes ☐ No

Home Address: _____
Street Address
_____
City *State* *Zip code* *Country*

Home Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐
(*Area Code*) ### - ####

Employer Name & Address: _____
Employer Name
_____
Street Address
_____
City *State* *Zip code*

Work Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐
(*Area Code*) ### - ####

Household Members:

Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*

Have you applied for Medical Assistance ☐ Yes ☐ No

If yes, what was the date you applied? ☐☐/☐☐/☐☐☐☐ *(MM/DD/YYYY)*

If yes, what was the determination?

Do you receive any type of state or county assistance? ☐ Yes ☐ No

Hospital Name
Return Address

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	
Retirement/pension benefits	
Social security benefits	
Public assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self employment	
Other income source:	
Total	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total	

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home : Loan Balance: _____ Approximate value: _____

Automobile: Make: _____ Year: _____ Approximate value: _____

Additional vehicle: Make : _____ Year: _____ Approximate value: _____

Additional vehicle: Make: _____ Year: _____ Approximate value: _____

Other property: _____ Approximate value: _____

Total _____

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car payment(s)	
Credit card(s)	
Car insurance	
Health insurance	
Other medical expenses	
Other expenses	
Total	

Do you have any other unpaid medical bills? ☐ Yes ☐ No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____

Applicant signature *Date* *Relationship to Patient*