

**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

# 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:

_____ <i>Name</i>	_____ <i>Age</i>	_____ <i>Relationship</i>
_____ <i>Name</i>	_____ <i>Age</i>	_____ <i>Relationship</i>
_____ <i>Name</i>	_____ <i>Age</i>	_____ <i>Relationship</i>
_____ <i>Name</i>	_____ <i>Age</i>	_____ <i>Relationship</i>
_____ <i>Name</i>	_____ <i>Age</i>	_____ <i>Relationship</i>
_____ <i>Name</i>	_____ <i>Age</i>	_____ <i>Relationship</i>
_____ <i>Name</i>	_____ <i>Age</i>	_____ <i>Relationship</i>
_____ <i>Name</i>	_____ <i>Age</i>	_____ <i>Relationship</i>

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:	_____
<b>Total</b>	_____

## II. Liquid Assets

### Current Balance

Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
<b>Total</b>	_____

## 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: _____
		<b>Total</b> _____

## IV. Monthly Expenses

### Amount

Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
<b>Total</b>	_____

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