

Maryland State Uniform Financial Assistance Application

Name:

First Middle Initial Last

Home
Address:

Street Address Unit

City State Zip Code Country

Is this your primary residence? Yes No

If not, do you live in Maryland for more than 6 months of the year? Yes No

Phone
Number:

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Area Code ### #####

I. Household/Family Members

Please list any of the following, if applicable: (1) A spouse (regardless of whether you file a joint federal or state tax return), (2) Children (biological, adopted, or stepchildren); and (3) All individuals listed on your tax return (anyone for whom you claim a personal exemption).

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

II. Family Income

Please list your total monthly or annual taxable income (before taxes). You may be asked to provide proof of income.

Note: If you have no income, please provide a letter of support from the person providing your housing or meals.

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III. Financial Hardship

Do you have any unpaid out-of-pocket expenses for hospital services (excluding amounts covered by your insurance) incurred by your household/family?

Yes No

If yes,

1. Have you applied for Maryland Medical Assistance (Medicaid)?

Yes No

If yes, what was the date you applied?

If yes, what was the determination?

2. Please list the total amount of your out-of-pocket expenses.

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IV. Assets

Please list the total value of monetary assets in excess of \$100,000. Include cash on hand, bank deposits, investment accounts, accounts receivable, and notes receivable. Do not include retirement assets.

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By signing this form, I certify that the information provided is true, accurate, and complete. I agree to notify the hospital of any changes to this information within 240 days of receiving the initial hospital bill.

Applicant signature

Date

Relationship to Patient