Meritus Medical Center has a Financial Assistance Program available for patients who find that they are unable to pay all or part of their medical bills. This program is based on the Federal Income Guidelines of the household, assets owned by the household and household size. Please complete the entire application and return it with the required documentation to:

Meritus Medical Center
Attn: Patient Accounts/FA
11116 Medical Campus Road
Hagerstown, MD 21742

Required Information and/or Documentation:

- You must provide proof of income. For example a copy of your federal income tax return or three (3) current copies of your pay stubs.
- If you are claiming no income on your application you must include a signed letter of support form the person or organization providing you with your day to day living expenses.
- If a "household member" has a current open account with the hospital and you want this account to be considered for financial assistance please list their social security number on the form.
- If you were denied for Medical Assistance within the last 90 days please attach a copy of the denial to your application.

Helpful Hints:

- Household members are defined as someone who is listed on your Federal Income Tax Form.
- Regular monthly payments are expected until your application is processed and you receive an approval letter in the mail.

An acknowledgement letter will be mailed to you within two business days of receipt of your application. If additional information and/or documentation is required we will contact you by phone or by mail within two business days.

You will be notified in writing of the disposition (decision) regarding this application within 30 days of the completed application. If you have any questions or concerns about your application please contact us at (240) 313-9500.

Sincerely,

Customer Service Representative
Meritus Medical Center

Meritus Medical Center

Maryland State Uniform Financial Assistance Application

Information About You Name _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members: (Household members are defined as someone who is listed on your Federal Income Tax Form)

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

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.

Meritus Medical Center

Maryland State Uniform Financial Assistance Application

	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