Meritus Health has a Financial Assistance Program available for patients who find 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/Financial Assistance
11116 Medical Campus Road
Hagerstown, MD 21742

Helpful Hints:

- Please make sure that you include all of the required documentation with your application to avoid any delay in processing your application.
- If you have applied for Financial Assistance in the past, you must submit new and current documentation with your application. We cannot use information from your previous application.
- **Regular Monthly payments are expected until your application is processed and you receive an approval letter in the mail.**

If additional information and/or documentation are required we will contact you by phone or by mail within two (2) business days. You will be notified in writing of the decision regarding this application within 30 days of the completed application. If you have any questions or concerns regarding your application please contact a Financial Counselor at (301) 790-8247 Monday through Friday between the hours of 7:30 am and 4:00 pm.

Sincerely,

Financial Counselor
Meritus Health

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
Indicate Service Location:_____

Home Address _____ Phone _____

_____

_____ _____
City State Zip code County

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	Social Security Number

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.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income (include copy of tax returns)	_____
Strike benefits	_____
Military allotment	_____
Farm or self-employment (include copy of tax returns and Schedule C)	_____
Other income source	_____
Child Support	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts (Pension, IRA, Etc.)	_____
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) (Minimum Payments)	_____
Car insurance (Monthly Amount)	_____
Health insurance	_____
Other medical expenses	_____
Other expenses (include food and gas for vehicles)	_____
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

Checklist of information that MUST be attached to this Financial Application:

_____ Current Income Tax return for previous calendar year (if business owner, Schedule C is required). If not returned, why? _____

_____ Three current pay stubs from employer for applicant and spouse. If not returned, why? _____

_____ Bank Statement for Check/Savings account on bank letterhead. If not returned, why? _____

_____ Social Security, Pension and/or disability

_____ Unemployment amount received

_____ Food Stamps and any government assistance

_____ Child Support

_____ Copy of Social Security Card

_____ Signed letter of support detailing how living expenses are being met (signed by the person providing support)

_____ Equipped for Life patient will need script from Doctor

HAVE YOU:

_____ Signed the application?

_____ Completed the application?

Please use this as a checklist so you do not forget any information that would cause your application to be denied. If you have any questions about the application and its process please call (301) 790-8247.