



BROOK LANE
Hope • Healing • Recovery

Meritus Health
11116 Medical Campus Road
Hagerstown, MD 21742
Phone (301) 790-8247

Meritus Health offers a Financial Assistance Program to help patients who are unable to pay all or part of their medical bills. Eligibility is based on household income and household size, using Federal Poverty Guidelines.

You may apply online through your MyChart account or by completing a paper application. If submitting a paper application, please complete all sections and return it with the required documentation to:

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

Applying through MyChart

1. Log in to your MyChart account.
2. Select Billing.
3. Choose Financial Assistance.
4. Complete the application and upload the required documents.

If additional information or documentation is needed, we will notify you through MyChart, by phone, or by mail. You will receive a written decision within 30 days after we receive a completed application.

If you have questions or need help with your application, please contact a Financial Counselor at (301) 790-8247, Monday through Friday, from 7:30 a.m. to 4:00 p.m.

Financial Counselor
Meritus Medical Center

Maryland State Uniform Financial Assistance Application

Name:

First	Middle Initial	Last
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Home
Address:

Street Address	Unit
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City	State	Zip Code	Country
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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:

() -
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).

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

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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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