Frederick Health

Frederick Health Hospital 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:

Frederick Health Hospital
Attn: Patient Accounts/Financial Assistance
400 West 7th St
Frederick, MD 21701

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.

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 (240) 566-4214 Monday through Friday between the hours of 7:30 am and 4:00 pm.

Sincerely,

Financial Counselor
Frederick Health Hospital

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:

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? _____

Do you receive any type of state or county assistance? Yes No

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	_____
Total	**_____**

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
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

_____

Relationship to Patient

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

Financial Documentation

Please submit the following financial documentation to assist with processing your application. **A current income tax return is the *preferred* method for determining household income**.

_____ Current Income Tax return **form 1040** for previous calendar year (if business owner, Schedule C is required). If not returned, why? _____

Or three of the following

_____ 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

_____ Child Support

_____ Food Stamps and any government assistance

If you have no income please provide the following

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

Don't forget, 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 (240) 566-4214.