



Frederick Health Hospital and Frederick Health Medical Group, entities of Frederick 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:**

Via Mail: **Frederick Health Attn: Financial Counseling 400 West Seventh St. Frederick, MD 21701**

Via Drop of location: **Cashier's Office 400 West Seventh St Frederick, MD 21701**

**You may also submit requested documents via our email address:  
FinancialAssistance@Frederick.Health**

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.
- Frederick Health Financial Assistance policies are available for review at **<https://www.Frederickhealth.org/about/billing-financial-assistance/>**.

If additional information and/or documentation are required, we will contact you by phone or by mail. You will be notified in writing of the decision regarding this application within 14 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 9:00 am and 4:00 pm.

Sincerely,

**Financial Counselors  
Patient Financial Services  
Frederick Health 400  
West Seventh St.  
Frederick, MD 21701  
Fax (240) 566-7944**

# Maryland State Uniform Financial Assistance Application

Name:

<i>First</i>	<i>Middle Initial</i>	<i>Last</i>
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Home Address:

<i>Street Address</i>			<i>Unit</i>
<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Country</i>

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:

( <input style="width: 40px; height: 20px;" type="text"/> )	<input style="width: 40px; height: 20px;" type="text"/> -	<input style="width: 40px; height: 20px;" type="text"/>
<i>Area Code</i>	<i>###</i>	<i>####</i>

## ***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>
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**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.*

\$

**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.

\$

**IV. Assets (optional for hospitals to include)**

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.

\$

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*

**\*\*For those that are uninsured we will refer you to attempt to qualify you for any Federal or State available insurance coverage. You are required to follow through/comply with government required application process.**

**Market Place/Medicaid Expansion (HELP) Insurance**

\_\_\_ Proof of application being accepted with effective date of coverage.

\_\_\_ Proof of application being filed and coverage denied.

**Current approval letter for the following public assistance:**

\_\_\_ Snap(Food Stamps) \_\_\_ Housing \_\_\_ M.E.A.P. (Energy Assistance)

\_\_\_ Temporary Cash Assistance (TCA) \_\_\_ Other

**Required residency documents:**

Have you been living in the U.S. less than 6 months? Yes \_\_\_ No \_\_\_

Please indicate your current status.

Citizen \_\_\_ Resident \_\_\_ Tourist \_\_\_ Other \_\_\_

Provide a form of identification.

Passport \_\_\_ Driver's License \_\_\_ Student ID/Work permit \_\_\_

**Earnings for all working members of the household:**

\_\_\_ 1040 Federal Tax Return, most current year filed.

\_\_\_ W-2, most current year received.

\_\_\_ 1099 or Social Security 1099.

\_\_\_ Pay stubs, most current 3.

\_\_\_ Year-to-date Profit and Loss Statement for self-employed.

**Other Earnings:**

\_\_\_ Unemployment compensation.

\_\_\_ Workers' Compensation.

\_\_\_ Social Security and Pension Earnings (Example: award/benefit letter).

\_\_\_ Veterans' payments.

\_\_\_ Other Federal or State assistance/payments.

\_\_\_ Survivor benefits.

\_\_\_ Interest and Dividends.

\_\_\_ Rentals.

\_\_\_ Royalties.

\_\_\_ Income from estates.

\_\_\_ Trusts.

\_\_\_ Educational assistance.

\_\_\_ Alimony.

\_\_\_ Child Support.

\_\_\_ Assistance from outside the household.

**Assets:**

3 months, current, complete and official checking acct stmts     I don't have one.

3 months, current, complete and official savings acct stmts     I don't have one.

3 months, current, complete and official investment acct stmts     I don't have one.

Written explanation of periods without income. How were you paying for food and housing?

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If someone is providing food and housing, and/or claims you as a dependent on their taxes, please include a signed letter of support from the individual(s) helping you.