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:**

Frederick Health
Attn: Financial Counseling
400 West Seventh 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. 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
Office (240) 566-4214
Fax (240) 566-7944

Maryland State Uniform Financial Assistance Application

Information About You:

Name: _____ Patient Name: _____

Birth Date: _____ Social Security No# ____-____-____

Martial Status: _____ US Citizen?: _____ Yes _____ No

Permanent Resident: _____ Yes _____ No

Home Address: _____ Phone: _____

_____ _____, _____
City State Zip Code

Employer Name: _____ Phone: _____

Work Address: _____

_____ _____, _____
City State Zip Code

Household Members:

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
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

****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____ StudentID/Work permit____

Earnings for all working members of the household:

____1040 Federal Tax Return, most current year filed.
____W-2, most current year received.
____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 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 and complete checking account statements ____I don't have one.
____3 months, current and complete savings account statements ____I don't have one.
____3 months, current and complete investment account statements ____I don't have one.

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

_____

_____

_____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.