UNIVERSITY of MARYLAND MEDICAL SYSTEM

Financial Assistance Program Application

Please complete, sign, and return this application with the following required documentation:

- **Income (Including all of the following documents you currently receive):**
  - ☐ Copy of last 2 pay stubs or copy of W-2 form from current tax year filed including patient, patient spouse and/or patient guarantor (parents/legal guardians of children under 18 yrs old) living in the household.
  - ☐ If self-employed, a copy of your current Federal Tax form 1040.
  - ☐ Documentation of Social Security/Social Security Disability or any other additional household income.
- **Copy of Mortgage/Rent Bill, or copy of Property Tax statement if home is no longer mortgaged**
- **If you applied for Medical Assistance, a copy of your approval or denial letter.**

If you are unable to supply any of the required documents above, please complete form FAF 116, page 3 below.

Patient Information		
Last Name:	First:	M.I.:
Social Security #:	Date of Birth:	

Guarantor (Legal Parent, Guardian, or Power of Attorney) If same as Patient skip to Part II; complete all fields.			
Last Name:	First:		M.I.:
Social Security #:	Date of Birth:	Relationship to Patient:	
Part II (Patient/Guarantor Information)			
Street Address:			Apt:
City:	State:	ZIP:	
Home Phone: ( )	Cell Phone: ( )	Marital Status:	
Employers Name and Address:			
Monthly Gross Income: $	Monthly Net Income: $		
Position/Title:	Length of Current Employment:		
Are you a Legal Resident of the United States: Yes ☐	No ☐		

Spouse		
Last Name:	First:	M.I.:
Employer Name/Address:	Phone #:	
Position/Title:	Length of Employment:	
Monthly Gross Income: $	Monthly Net Income: $	

Household Information (Name and Date Of Birth of all persons in household, excluding self or spouse)		
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:

Additional Household income	
Checking Account Balance:	Monthly Unemployment Amount:
Savings Account Balance:	Monthly Social Security Amount:
Public Assistance/ Food Stamps:	Monthly Workers Compensation Amount:
Monthly/Annual Pension Amount:	Any Other:

Mortgage/Rent (Copy of Mortgage/Rent payment required)	
Mortgage/Rent Payment:	

Health Insurance Information (Copy of Medical Assistance Approval or Denial letter you received is required)		
Name Of Company:		Effective Date:
Have you applied for Medical Assistance: Yes ☐ No ☐		When:
Where:	Name of Caseworker & phone #:	
Outcome/Reason for Denial:		

Disability Information		
Is the Patient Disabled: Yes ☐ No ☐		Length Of Disability:
Name of Physician:		Physician Phone Number:

Third Party Liabilities (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim)			
Injuries/Illness result of an Auto Accident	Yes ☐	No ☐	Date of Incident:
Injuries/Illness occuring at your workplace?	Yes ☐	No ☐	Date of Incident:
Injuries/Illness result of a Crime?	Yes ☐	No ☐	Date of Incident:
Injuries/Ilness resulting in legal action?	Yes ☐	No ☐	Date of Incident:

Third Party Liability Claims are ineligible for Financial Assistance until all means of payment are exhausted. Failure to disclose information pertaining to any third party liability claim will deem patient ineligible for Financial Assistance.

I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to UMMS and it's practices is true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges. By signing and submitting this request, I give UMMS, and it's facility practices permission to determine my need for financial assistance; including review of my credit file. I also give permission to UMMS to release or disclose this information to University Physicians Inc. for the purpose of evaluating my financial status in response for assistance with my physician bills. I understand that it is my responsibility to advise UMMS of any changes in status in regards to my income or assets while this application is in process.

Patient/Guarantor Signature (required) _____ Date _____

Spouse's Signature (required) _____ Date _____

If you have any questions or need assistance completing this application, please call the Financial Assistance Dept. (410) 821-4140, Extension 2003, Monday through Friday, 8:00am - 4:30pm.

You may mail, email or fax this application along with required documents to:

Mail: UMMS
11311 McCormick Road, Suite 230
Hunt Valley, MD 21031

Email: CBOService@umm.edu

Fax: 410-630-5341

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Verification of Living, Financial, and Income Statement

This form will need to be completed by a Financial Assistance applicant who:

- Receives assistance with food and/or shelter
- Currently unemployed
- Hospital bills due to injuries from an auto accident, workers compensation, personal injury, or any other third party liability claim

Patient Information:

Name: _____ Date: _____

Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Patient Signature: _____

If receiving assistance with food and shelter, complete the following**:**

I have been receiving assistance from _____, who has been assisting me with food and shelter. Relationship to patient: _____.

(Check one)

_____ Providing room and board free

_____ I have been paying $ _____ per month for room and board

_____ Other, please explain below:

_____

_____

_____

If unemployed and receiving no income, complete the following**:**

(Check one) __ I have been unemployed since ___/___/___ and receiving assistance with food and shelter per above. Expected date to return to work? _____

__ I have been unemployed since ___/___/___ and living off of savings or other monetary assets.

Please explain in detail: _____

_____

Expected date to return to work? _____

Why are you not receiving unemployment income?

(Check one) ___ Eligibility Expired - Patient has exhausted all eligible unemployment benefits.

___ Not Eligible, reason: _____

If you have a third party liability claim (Auto accident, workers compensation, personal injury) complete the following:

Attorney: : Name: _____

Address

Phone Number: _____

Insurance Company: Name: _____

Address: _____

Phone Number:_____

Expected Settlement Date: _____/_____/_____