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
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

Hospital Name Calvert Memorial Hospital
Return Address 100 Hospital Road
Prince Frederick, MD 20678

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 _____**

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		approximate value _____
Automobile	Make ____	Year ___	Approximate value _____
Additional vehicle	Make ____	Year ___	Approximate value _____
Additional vehicle	Make ____	Year ___	Approximate value _____
Other property			Approximate value _____
			Total

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
-Health-insurance—	
Other medical expenses	_____
Other expenses	_____
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