MedStar Health Uniform Financial Assistance Application

Patient Account Number(s):_____

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
Advocate that completed or mailed F/A Application:_____Date:_____

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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 __N/A___ Year __N/A____	Approximate value _____N/A_____
Additional vehicle	Make ___N/A__ Year _ N/A____	Approximate value ____ N/A_____
Additional vehicle	Make ___N/A____ Year __N/A__	Approximate value _____N/A_____
Other property		Approximate value _____N/A_____
		Total _____

IV. Monthly Expenses

	Amount
Rent or Mortgage	____N/A_____
Utilities	____N/A_____
Car payment(s)	____N/A_____
Credit card(s)	____N/A_____
Car insurance	____N/A_____
Health insurance	____N/A_____
Other medical expenses	_____
Other expenses	____N/A_____
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