Maryland State Uniform Financial Assistance Application

Name: _____

First *Middle Initial* *Last*

Home Address: _____

Street Address *Unit*

_____

City *State* *Zip Code* *Country*

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: (☐) ☐ - ☐

Area Code *###* *####*

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).

Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
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Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*

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.

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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.

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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.

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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*