MedStar Health Uniform Financial Assistance Application

Patient Account Number(s):_____

Information About You

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Name						
First	Middle		Last			
Social Security Number		Marital Status: Single Permanent Resident:		Married Yes No	-	
					100 110	
Home Address _				Phone		
City	State	Zip code		Country		
Employer Name				Phone		
Work Address _						
City	State	Zip code				
Household memb	bers:					
Name		Age	Relationship			
Name		Age	Relationship			
Name		Age	Relationship			
Name		Age	Relationship			
Name		Age	Relationship			
Name		Age	Relationship			
Name		Age	Relationship			
Name		Age	Relationship			
If yes, what was	I for Medical Assistance the date you applied?	Yes	No			
-	the determination? ny type of state or county	assistanc	ce? Yes I	No		
	mpleted or mailed F/A Ar				Date:	

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	MakeN/A	Year <u>N/A</u>	Approximate value	N/A
Additional vehicle	MakeN/A	Year _ N/A	Approximate value	N/A
Additional vehicle	MakeN/A	YearN/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			1 \/ / 1	_
Other expenses			N/A	
other expenses			Total	_
Do you have any other unpaid medical bills?		Yes No		
For what service?	•			

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