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 County

Employer Name ______________________________________ Phone______________

Work Address ______________________________________

____
City State Zip Code

Household members:

Name	Date of Birth	Age	Relationship	Have you ever been a patient at NWH?	Yes	No
					○	○
					○	○
					○	○
					○	○
					○	○
					○	○

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 ○

Return application to: Northwest Hospital
5401 Old Court Road Patient Financial Services
Attention: Customer Service
Randallstown, Md, 21133

For Hospital / Department / Agency use only

Originator Name: ______________________________

Department: ______________________ **Ext** __________

Agency Name: ______________________________

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1. *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 __________

Total: __________

IV. Monthly Expenses

	Amount
Rent or Mortgage	__________
Utilities	__________
Car Payment(s)	__________
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 your 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.

X________________________________ **X**________________________________

Applicants signature Date

X

Relationship to Patient