Dear Sir/Madam:

Garrett County Memorial Hospital (GCMH) is pleased to offer financial assistance to individuals of our community who may need help with the payment of charges for medical services obtained at GCMH regardless of whether you do or do not have insurance.

The following information is **required** to determine your eligibility:

1. Your Medical assistance status.

   To apply for Medicaid of Maryland call 855-642-8572 or go on-line at www.marylandhealthconnection.gov

   You may also contact either Social Services at 301-533-3000 (aged, blind, disabled) or Healthy Families at 301-334-7720.

   (Out of state patients may contact their local health department.)

2. Your proof of income:

   If you are on a fixed monthly income please include a copy of your Award Letter or a current bank statement.

   If you are Self Employed, please include a copy of your current Federal Income Tax form 1040 along with the Schedule C or C-EZ Profit or Loss from Business form, Schedule E or Schedule F (whichever is applicable).

   If you are Employed, please include either a copy of your Current Federal Income Tax form 1040 (with appropriate Schedule attached) or a copy of your paystubs for the last 3 months (either 6 bi-weekly or 12 weekly).

   If you are Unemployed, please include a copy of your Initial Award Letter or bank statement or Webcert information.

To save time processing your application, remember to only include under Household Members yourself, wife/husband, children or those you can claim on your Federal Income Tax form and return the form within 30 days. Be sure to complete the application in full (front and back) as well as sign and date it.

Once your application is received, please allow 7-10 days for processing. You will receive a letter indicating your Care Program Application status at that time.

In addition, we will be sending you a business card showing your eligibility to the Caring Program. When you come into the hospital and register for services, please show the business card to the registration clerk and she will set up the Caring Program on your account.

If you have any questions about the completion of the financial assistance process, please do not hesitate to contact me at the number below.

Last name beginning with	A-E	call Roberta	301-533-4213
	F-K	call Trisha	301-533-4211
	L-R	call Jayne	301-533-4212
	S-Z	call Missy	301-533-4354

Note: Your application cannot be processed without your proof of income and Medicaid denial letter.

MARYLAND STATE UNIFORM ASSISTANCE APPLICATION

Information About You:

Name____

First Middle Last

Social Security #_____-_____-_____ Marital Status: single married separated
US Citizen: Yes No Permanent Resident Yes No

Home Address______________________________ Phone______________

____

____
City State Zip Code

Employer Name_____________________________ Phone_______________

Address___________________________________

____
City State Zip Code

Household Members (only members that you could claim on a tax return. Please include yourself)

Name	Age	Relationship
___________________	________	______________
___________________	________	______________
___________________	________	______________
___________________	________	______________
___________________	________	______________

Have you applied for Medical Assistance in the state in which you live? ___________________
My Medical Assistance Application appointment is scheduled for ________________________
Do you receive any other type of state or county assistance? Yes No
Explain____
____
____

Garrett County Memorial Hospital
251 North 4th Street
Oakland, MD 21550

Telephone 301-533-4213
Fax 301-533-4208

Please complete and sign the back side of this application…………………………………..

Family Income

List the amount of your monthly income from all sources. ***YOU ARE REQUIRED*** to supply proof of income and assets. If you have no income you must request and complete a proof of no income form.

	His monthly	Her monthly
Employment (3 months pay stubs or tax return-no W2's)	____________	______________
Retirement / Pension Benefits	____________	______________
Social Security Benefits	____________	______________
Public Assistance Benefits	____________	______________
Disability Benefits	____________	______________
Unemployment Benefits	____________	______________
Veteran's Benefits	____________	______________
Alimony / Child Support	____________	______________
Rental Property Income	____________	______________
Military Allotment	____________	______________
Farm or Self Employment	____________	______________
Other income source (__________________)	____________	______________

Liquid Assets	Current Balance
Checking account	_____________________________
Savings Account	_____________________________
Stocks, Bonds, CD, or Money Market	_____________________________
Other Investments	_____________________________

Other Assets

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

Home: Year Financed_______ Loan term________ Approximate value_________________________

Automobile: Make______________ Year ________ Approximate value_________________________

Automobile #2: Make___________ Year ________ Approximate value _________________________

Monthly Expenses (proof may be requested)

Rent / Mortgage	$_________________	Medication	$___________________
Heat, Electric, Cable	$_________________	Health Insurance	$___________________
Telephone/Cell	$_________________	Doctor Bills	$___________________
Credit card #1	$_________________	Other Hospital	$___________________
Credit card #2	$_________________	Drug store items	$___________________
Credit card #3	$_________________	Other medical expenses	$___________________
Car Payment	$_________________	Other	$___________________
Car Insurance	$_________________	Medical Equip Rentals	$___________________
Child Support	$_________________	Day Care	$___________________
Gasoline	$_________________	Life Insurance	$___________________
Homeowner Ins	$_________________	Food	$___________________
Other_______________________________		Other____________________________________	

If you request the hospital extend additional financial assistance, the hospital may request additional information in order to make 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's Signature____ Date____________________________