UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

UM Upper Chesapeake Health has a Financial Assistance Program based on financial need.

Please complete and return the attached form and required documents within 15 days.

This information will be held in the strictest confidence and is necessary to determine eligibility.

Within two (2) business days of receipt of the Financial Assistance Request, the hospital will make a determination of probable eligibility.

Thank you for choosing **UM Upper Chesapeake Health**

We would like to assist you with the **Financial Assistance** process. Please complete the attached form and return it to us **within 15 days** with the requested information from the list below. This information will be held in the strictest confidence and is necessary to determine eligibility. Within two (2) business days of receipt of the Financial Assistance Request, the hospital will make a determination of probable eligibility. If you are unable to provide this information within that time frame, please contact:

Tammy Johnson, Financial Counselor
(443) 843-5092

In order for you to qualify for **Financial Assistance**, we are required to obtain the completed and signed application along with the following:

- **Copies of all pages of your last three (3) bank statements**
  - Must be copies of original bank statements showing bank's name and all account holders' names
  - Need copies for applicant and spouse
  - If there are deposits other than payroll, please provide an explanation
- **Copies of your last three (3) pay stubs**
  - Need copies for applicant and spouse
- **Copies of all pages of your current income tax return and W-2's**
- **Copies of any benefits you are receiving**
  - Social Security benefit letter
  - Unemployment notifications
  - Disability benefit letters
  - Proof of any public assistance
    - Food Stamps
    - WIC program
    - Primary Adult Care Program
    - Energy Assistance
    - Free or reduced lunch plans
- **If there is no income**, you will need to call me to obtain a copy of our Verification of No Income form

Please be assured that this information is necessary to determine your eligibility.

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Maryland State Uniform Financial Assistance Application

Information About You

Name: _____
First *Middle Initial* *Last*

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐ Marital Status: ☐ Single ☐ Married ☐ Separated

US Citizen: ☐ Yes ☐ No Permanent Resident: ☐ Yes ☐ No

Home Address: _____
Street Address
_____
City *State* *Zip code* *Country*

Home Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐
(*Area Code*) ### - ####

Employer Name & Address: _____
Employer Name
_____
Street Address
_____
City *State* *Zip code*

Work Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐
(*Area Code*) ### - ####

Household Members:

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

Have you applied for Medical Assistance ☐ Yes ☐ No

If yes, what was the date you applied? ☐☐/☐☐/☐☐☐☐ *(MM/DD/YYYY)*

If yes, what was the determination?

Do you receive any type of state or county assistance? ☐ Yes ☐ No

If Yes, please attach a copy of your benefit letter as proof of this assistance.

Please return application to:
UM Upper Chesapeake Health
Patient Accounting Department
2027 Pulaski Highway, Suite 215
Havre de Grace, MD 21078

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. Within two (2) business days following a patient's request for Financial Assistance the hospital will make a determination of probable eligibility.

	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: _____

Other property: _____ Approximate value: _____

Total _____

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car payment(s)	
Credit card(s)	
Car insurance	
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 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*