MEDICAL SYSTEM

Financial Assistance Application

Thank you for choosing **Shore Health System** for your health care needs. We are dedicated to assisting our community with obtaining necessary medical care regardless of their ability to pay. The following guidelines and information have been established to assist you through this process.

If **Shore Health System** determines that you are potentially eligible for Maryland Medical Assistance through the Department of Social Services (DSS), you may be REQUIRED to apply for such assistance and provide a written denial from DSS **before** being considered for financial assistance from **Shore Health System**. Financial assistance may not be available to individuals who reside outside our service area.

Financial Assistance may **not** cover the following:

- Charges for which a judgment has been rendered. (You will be responsible for resolving those outstanding amounts)
- Pending Third Party Liability claims, for example worker's compensation claim, motor vehicle accident claim, etc.
- Elective Non-Emergent Services
- Patient Convenience Items
- Services that would be covered by insurance if at another healthcare facility. (You must comply with all insurance requirements to obtain coverage through our program.)
- Physician bills and bills from other providers (for example, ambulance, radiology, etc. You should contact them directly.)

To be considered for financial assistance, please **complete and sign** the attached Financial Assistance Application and **submit** a copy of the following information:

- **Proof of your family income** (for example, most recent two pay stubs including year-to-date figures for each wage earner in the family, last year's W-2, most recent federal tax return, Letter for "Proof of Support" if you have no income and are being supported by another individual, etc.)
- If applicable, **Social Security Income** (Social Security award letter, copy of recent Social Security check or copy of bank statement if direct deposit)
- If applicable, **Determination Letter** from Medical Assistance
- Copy of **Mortgage and/or Rent Bill** (If you are currently living with family/friends, please write a letter of explanation of your housing situation.)

You may be required to submit additional information to support your application for final determination.

Please be assured that this information will be held in the strictest confidence and is necessary to determine your eligibility. Financial Assistance determinations are based on your current financial situation.

Please return your completed and signed application along with the requested documentation to:

Shore Health System
Patient Financial Services
Patient Financial Assistance Liaison
219 S. Washington Street
Easton, MD 21601

Shore Health System will notify you by letter of the outcome of your application.

If you have any questions regarding completing this application, please contact:

Shore Health System
Financial Assistance Department
410-822-1000 ext. 8619
800-876-3364 - Toll Free

MEDICAL SYSTEM

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 _____ Home Phone:

_____

_____ _____
City *State* *Zip code* *Country*

Employer Name _____ Work Phone

Work Address _____ _____

_____
City *State* *Zip 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

UNIVERSITY OF MARYLAND MEDICAL SYSTEM

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:	_____

Liquid Assets:	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other Accounts	_____
Total:	_____

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	_____

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*