UNIVERSITY of MARYLAND MEDICAL SYSTEM

Financial Assistance Program Application

Please complete, sign, and return this application with the following required documentation:

- **Income (Including all of the following documents you currently receive):**
  Copy of last 2 pay stubs or copy of W-2 form from most recent tax year filed for all who apply; including patient, patient spouse, patient guarantor (Parent(s) of children under 21 yrs old) living in the household. Documentation of Social Security/Social Security Disability or any other additional household income.
- **Copy of Mortgage/Rent Bill.**
- **If you applied for Medical Assistance, a copy of your approval or denial letter.**

If you are unable to supply any of the required documents above, please complete form FAF 116 attached.

Patient Information		
Last Name:	First:	M.I.:
Social Security #:	Date of Birth:	

Guarantor (Responsible Party) If same as Patient skip to Part II, otherwise complete all fields.			
Last Name:	First:		M.I.:
Social Security #:	Date of Birth:	Relationship to Patient:	
Part II (Copy of W-2 form(s) from most recent year filed OR last two pay check stubs required)			
Street Address:			Apt:
City:	State:	ZIP:	
Home Phone: ( )	Cell Phone: ( )	Marital Status:	
Employers Name and Address:			
Monthly Gross Income: $	Monthly Net Income: $		
Position/Title:	Length of Current Employment:		
Are you a Legal Resident of the United States: Yes ☐	No ☐		

Spouse		
Last Name:	First:	M.I.:
Employer Name/Address:	Phone #:	
Position/Title:	Length of Employment:	
Monthly Gross Income: $	Monthly Net Income: $	

Household Information (Name and Date Of Birth of all persons in household, excluding self or spouse)		
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:

Additional Household income

Checking Account Balance:	Monthly Unemployment Amount:
Savings Account Balance:	Monthly Social Security Amount:
Public Assistance/ Food Stamps:	Monthly Workers Compensation Amount:
Monthly Child Support Amount:	Other:

Monthly Expenses (Copy of Mortgage/Rent payment required)	
Mortgage/Rent Payment:	Cable:
Utilities:	Visa:
Telephone:	Mastercard:
Cell Phone:	Department Store:
Car Payment:	Other:

Health Insurance Information (Copy of Medical Assistance Approval or Denial letter you received is required)		
Name Of Company:		Effective Date:
Have you applied for Medical Assistance: Yes ☐ No ☐		When:
Where:	Name of Caseworker & phone #:	
Outcome/Reason for Denial:		

Disability Information			
Is the Patient Disabled:	Yes ☐	No ☐	Length Of Disability:
Name of Physician:			Physician Phone Number:

Third Party Liabilities (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim)			
Injuries/Illness result of an Auto Accident	Yes ☐	No ☐	Date of Incident:
Injuries/Illness occuring at your workplace?	Yes ☐	No ☐	Date of Incident:
Injuries/Illness result of a Crime?	Yes ☐	No ☐	Date of Incident:
Injuries/Ilness resulting in legal action?	Yes ☐	No ☐	Date of Incident:

Third Party Liability Claims are ineligible for Financial Assistance until all means of payment are exhausted. Failure to disclose information pertaining to any third party liability claim will deem patient ineligible for Financial Assistance.

I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to UMMS and it's practices is true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges. By signing and submitting this request, I give UMMS, and it's facility practices permission to determine my need for financial assistance; including review of my credit file. I also give permission to UMMS to release or disclose this information to University Physicians Inc. for the purpose of evaluating my financial status in response for assistance with my physician bills. I understand that it is my responsibility to advise UMMS of any changes in status in regards to my income or assets while this application is in process.

Patient/Guarantor Signature _____ Date _____

Spouse's Signature _____ Date _____

If you have any questions or need assistance completing this application, please call the Financial Assistance Dept. (410) 821-4140, Monday through Friday, 8:00am - 4:30pm. Mail this application, **along with required documents to: UMMS, 11311 McCormick Rd, Suite 230, Hunt Valley, MD 21031**.