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 ○	
				Yes ○	No ○	
				Yes ○	No ○	
				Yes ○	No ○	
				Yes ○	No ○	
				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 – Patient Financial Services
Attn: Customer Service
5401 Old Court Road
Randallstown, Md, 21133

For Hospital/Department/Agency Use Only

Originator Name: _____

Department: _____ **Ext** _____

Agency Name: _____

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