

# 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

\_\_\_\_\_

Country

Employer Name \_\_\_\_\_

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? \_\_\_\_\_

If yes, what was the determination? \_\_\_\_\_

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

**APPLICANTS MUST SUBMITT ALL REQUIRED DOCUMENTS IN THE SAME MAILING TO:**

Bon Secours Financial Assistance Program  
P.O. Box 742431  
Atlanta, GA 30374-2431

## ***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.

	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	_____
<b>Total</b>	_____

## ***II. Liquid Assets***

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
<b>Total</b>	_____

## ***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 _____
<b>Total</b>		_____

## ***IV. Monthly Expenses***

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
<b>Total</b>	_____

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

