MWPH Patient Financial Assistance Policy - ATTACHMENT B
Please return form along with:

1. **Two most recent pay stubs**
2. **Most recent statements from any/all bank accounts**

Information should be submitted from each custodial parent/guardian.
Thank you.

Maryland State Uniform Financial Assistance Application

Patient Name _____ ***Date(s) of Service*** _____ ***Acct #: F*** _____

Information About Guarantor

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

Have you applied for Medical Assistance for the patient? 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 form to:
Mt. Washington Pediatric Hospital, 1708 W. Rogers Avenue, Baltimore, Maryland 21209
Attention: V.P. Finance

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	_____
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.

_____ _____

Guarantor signature Date

_____

Relationship to Patient