Hospital Financial Assistance Program

Thank you for choosing Saint Agnes Hospital for your medical needs.

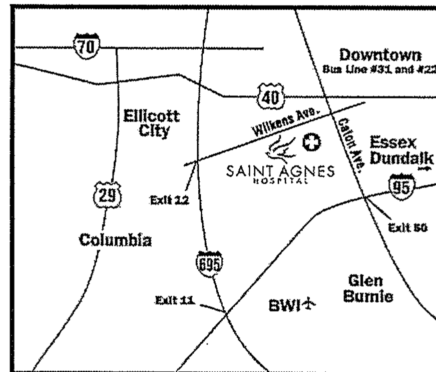
You have expressed an interest in applying for our Hospital Financial Assistance Program. In order to be considered, the required documents must be received in our office:

- Completed application
- Prior years' Federal Income Tax Return
- Proof of current income or, if unemployed, proof of employment compensation or letter of support
- Proof of any investigations
- A copy of checking and/ or savings account books
- Copies of any unpaid medical bills

Upon completion of the evaluation process, you will be notified of the percentage of allowance, if any, to be applied to your outstanding accounts.

If we do not receive the required information requested within 15 days, we will follow our normal collection practices. If you have any questions or concerns, please contact a Patient Account Representative at 667-234-2140.

Thank you for choosing Saint Agnes Hospital for your medical needs!



900 S. Caton Avenue
Mailstop 045
Baltimore, MD 21229
667-234-2140
TTY: 667-234-2001
www.TeamSaintAgnes.com

PATIENT FINANCIAL SERVICES

Maryland State Uniform Financial Assistance Application

Maryland State Uniform Financial Assistance Application

Information About You

Name: ______________________
First Middle Last

Social Security Number: ______________

Date of Birth: ______________

Marital Status: Single Married Separated

US Citizen: Yes No

Permanent Resident: Yes No

Home Address: ______________

____

City State Zip Code

Country Phone

Employer Name: ______________

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
Name	Age	Relationship
Name	Age	Relationship

Have you applied for Medical Assistance?
Yes No

If yes, what date did you apply? ______________

If yes, what was the determination? ______________

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

I. Family Income

	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 sources	
Total	

II. Liquid Assets

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:________ Value:________

Auto: Make:______ Year:______ Value:_____

Auto: Make:______ Year:______ Value:_____

III. Other Assets cont.

Auto: Make:______ Year:______ Value:_____

Other property: ______________

Total ______________

IV. Monthly Expenses

	Monthly 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 If yes, amount ______________

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

____
Relationship to Patient

____
Date