CalvertHealth Medical Center

Dear

You have expressed an interest in the CalvertHealth Medical Center Assistance Program (Charity Care Program). We understand there are times that health care financial obligations can be overwhelming.

Our charity care program is offered to patients who meet the criteria based on the guidelines established by the Federal government for Charity Care. You will find the attached application and a list of the documents needed to support the application

Please complete the application in full, date and sign and return to Jo Anne Green in Patient Financial Services. This request needs to be complete and returned with the supporting documents within 15 days. It is important that all needed documents be returned in order not to delay the process.

Once all criteria are returned the application is then forwarded to the appropriate reviewers for approval and signature.

If approved or denied our patients are notified by letter of the outcome.

Questions can be directed to Jo Anne Green 410-535-8268.

MR#_____ Information must be received by: ☐ **Date:** _____

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Proof of Income	Proof of Identity	Proof of Expenses
□ Paystubs last__3_____	□ Social Security Cards	□ Water, sewer, garbage bills
□ Statement on employer letterhead	□ Birth Certificate/Baptism Certificate	□ Utilities
□ Tax Return for 20_23___	□ Drivers License	□ Rent/Mortgage Receipts
□ Unemployment Benefits	□ Alien Registration	□ Shared expenses
□ Union/Strike Benefits	□ Marriage License	□ Child/adult dependant care
□ Child Support/Alimony	□ Divorce Decree	□ Property Taxes/Homeowners Ins.
□ Social Security Benefits	□ Separation Agreement	□ Medical Bills
□ SSI/SSDI Benefits	□ Letter from outside source	
□ Veterans Benefits		
□ Education Loans/Grants/Scholarships	**Proof of Assets**	**Other Proofs**
□ Military Allotment		
□ Payments from others for expenses	□ 2Checking/Savings Statements in full	□ School Forms 604/690
□ Contributions received	□ CD's, IRA Accounts	□ Address of Absent Parents
□ From roomers/boarders	□ Stocks, Bonds, Mutual Funds	□ Pregnancy/Prenatal Care
□ Rental/Mortgage Income	□ Dividends of Interest	□ Disability/Incapacitation forms
□ Self Employment Records	□ Life and Health Insurance	□ Applications for other benefits
□ Workman's Compensation	□ Cars and Vehicle Loans	□ Proof of who lives with you
□ Wage Forms/Statements	□ Make/Model/Year- all cars	□ Report Cards
□ Pension Income	□ Transferred Assets within last 3 mo.	□ Type of Housing
□ Unemployment Letter	□ Property: Land, House, Other	□ Other information

****Important**** these proofs must include name, address and telephone number of the person making the statement.

Other Instructions:

Dear Patient,

You have requested assistance with your hospital bill at CalvertHealth Medical Center. We have received your application for Financial Assistance. There are supporting documents that are required in order to approve your request. Please return the above checked items and return to the hospital as soon as possible. Failure to comply with this request infers you are no longer interested in our program.

If you have any questions, please contact our Patient Advocate, JoAnne Green at 410-535-8268
Fax: 410-535-8796

Respectfully,

Maryland State Uniform Financial Assistance Application

CalvertHealth Medical Center

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: _____

_____

_____ County: _____
City State Zip

Employer Address: _____ Phone: _____

_____

_____ County: _____
City State Zip

Household members:

_____ _____ _____
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

I. Family Income

List the amount of your monthly income from all sources. You maybe 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	_____

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Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veteran's 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 _____ Yr. _____ Approximate value _____

Additional Vehicle: Make _____ Yr. _____ Approximate value _____

Additional Vehicle: Make _____ Yr. _____ Approximate value _____

Other property _____ Approximate value _____

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.

_____ _____ _____

Applicant Signature Date Relationship to Patient

CalvertHealth Medical Center
FINANCIAL ASSISTANCE
SUPPORTING DOCUMENTS

CalvertHealth Medical Center

ROOM AND BOARD STATEMENT

TO WHOM IT MAY CONCERN:

THIS IS TO VERIFY I, _____ HAVE BEEN PROVIDING

_____ WITH FREE ROOM AND BOARD

SINCE _____ AND WILL CONTINUE TO DO SO.

NAME: _____

RELATION: _____

ADDRESS: _____

_____

DATE: _____

PHONE: _____

SIGNATURE: _____

Support Letter

Maryland Uniform Financial Assistance

- Patients Name _____

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- Account Number _____
- How long you have known this person? _____

I am helping them meet their needs by: (check all that apply)

- ☐ food
- ☐ shelter
- ☐ help with bills (utilities, rent/mortgage, hospital, etc)
- ☐ money
- ☐ transportation
- ☐ other miscellaneous needs *(please specify)* _____
- ☐ dates of unemployment _____
- ☐ dates of homelessness _____

☐ I can verify that this patient did *not* file taxes for last year.

☐ Other: _____

_____

_____

_____

Name: _____Date: _____

Relationship to Patient: _____

Phone Number: _____

CalvertHealth Medical Center
Financial Assistance
Unemployment Document

Have you ever been employed?_____

Are you currently employed?_____

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Previous employer?_____

Last day of work?_____

Do you receive unemployment benefits?_____

What is your current income?_____

Signed:_____ Date:_____

I agree that the above statements are true and will be used to determine my eligibility for financial assistance from CalvertHealth Medical Center.