ATLANTIC
GENERAL HOSPITAL
care.givers

Financial Assistance Application

Atlantic General Hospital and Atlantic General Health System

ATTN: Financial Assistance, Box # 10

9733 Healthway Drive

Berlin, MD 21811-1155

410-629-6025 Office

410-641-9643 Fax

www.atlanticgeneral.org

Atlantic General Hospital and Atlantic General Health System offers a financial assistance program for patients who have a patient responsible bill, **for medically necessary services**, that they cannot afford.

There is an income guidelines chart available to determine if you would be eligible for the financial assistance program or not.

In order to be eligible for financial assistance, a patient must have a valid social security number, visa, or green card, and patients must apply within 240 days from the first patient responsible bill received.

A patient and his/her claimed dependents are automatically approved for 100% financial assistance for medically necessary services if the patient or a dependent has a means tested program such as food stamps, energy assistance, housing assistance, WIC, free or reduced school lunches, or SLMB. All the patient has to do is provide proof that he/she currently has one of these means tested programs.

If the patient and their dependents do not have any means tested programs, then he/she should submit a financial assistance application, their most recent federal tax return (1040) and proof of all gross income for past 12 months, for everyone on that 1040.

Income includes employment, social security, disability, unemployment, self-employment, rental income, retirement income, pension, etc.

The financial assistance program is based on family size per the patient's federal tax return (1040), and the entire household's gross income for the past twelve (12) months.

<u>The patient should submit the financial assistance application and/or financial documents to:</u>

Atlantic General Hospital
ATTN: Financial Assistance, Box #10
9733 Healthway Drive
Berlin, MD 21811

The application and/or financial documents can also be faxed to 410-641-9643, or dropped off to the Financial Assistance Office at Central Registration, Booth # 7, Atlantic General Hospital - Emergency Room, 9733 Healthway Drive, Berlin, MD 21811.

The patient should submit the financial assistance application and required documents as soon as possible. If all of the required documents are not received within three (3) weeks from the date the application is received, the application may be denied, and the patient will be responsible for the bill.

If a patient appears eligible for State Medical Assistance, then he/she must apply and get the results before we can finalize his/her financial assistance application.

Patients may be approved for 100% financial assistance, 75%, 50%, or 25% - - - - for medically necessary services.

If a patient and his/her claimed dependents have bills from Atlantic General Hospital totaling more than 25% of the total family income for the past twelve months, each dependent listed on the tax return may be eligible for financial assistance hardship.

Once the financial assistance application has been processed, a letter with the results will be mailed to the patient.

Atlantic General Hospital's financial assistance program is not insurance. It covers bills from Atlantic General Hospital, and Atlantic General Health System (doctors, surgeons, hospitalists, anestheologists, etc. that are employed by AGH) for medically necessary services, if the patient cannot afford the bill and is eligible for the financial assistance program. It does not include bills from other providers such as Emergency Service Associates, Delmarva Radiology, Peninsula Pathology, Delmarva Heart, etc. The patient must call these companies and inquire about their assistance programs.

Every time the patient gets a bill from Atlantic General Hospital or Atlantic General Health System, he/she must call the number on the bill and discuss his/her options.

If you have any questions about the financial assistance program, please call our Financial Counselor at 410-629-6025.

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

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

Please return the completed application and required documents to:

Atlantic General Hospital

ATTN: Financial Assistance, Box # 10

9733 Healthway Drive

Berlin, MD 21811

Maryland State Uniform Financial Assistance Application

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.

_____ _____

Applicant signature Date

_____

Relationship to Patient