Financial Assistance Application

Atlantic General Hospital

ATTN: Financial Assistance, Box # 10

9733 Healthway Drive

Berlin, MD 21811-1155

410-629-6025 Office

410-641-9210 Fax

www.atlanticgeneral.org

Atlantic General Hospital bases our Financial Assistance program on 200% to 500% of the Federal poverty guidelines. Eligibility is based on the previous twelve (12) months of income. **Each family member** who has a balance due at Atlantic General Hospital must complete a financial assistance application.

IMPORTANT NOTE: **Financial assistance cannot be applied, if you are not cooperative in the application process, do not follow your insurance guidelines, or if the account is for worker's compensation, litigation, or the balance pending an estate settlement. If approved, this financial assistance program covers bills from Atlantic General Hospital. It may not cover bills for other providers who rendered services, at Atlantic General Hospital, such as, but not limited to: Emergency Service Associates, Delmarva Radiology, Peninsula Cardiology, Delmarva Heart, Peninsula Pathology. You must contact them directly to inquire about assistance. If you are approved for financial assistance and return to the hospital within the approval period for another service we can require you to submit additional information.**

If you do not have health coverage, please research your insurance options under the Health Insurance Exchange, otherwise known as 'Obama care' (www.healthcare.gov).

You may be required to apply for State Medical Assistance before we can complete your application.

If you or any of your dependents listed on your current federal tax return (1040) have bills at Atlantic General Hospital totaling more than 25% of your total family income for the past twelve months, each immediate family member listed on your tax return and living in the same household may be eligible for financial assistance hardship (25% off your Atlantic General Hospital bills).

If you or any of the dependents listed on your current federal tax return (1040) are receiving food stamps, WIC, Energy Assistance, or reduced or free lunch, please completely fill out the front page of the attached application and Section 1 – Family Income on back of application, sign, and date it, provide proof that you are receiving assistance from one of these programs and a copy of your current federal tax return (1040) and you **may** be automatically approved for 100% financial assistance.

If you are **not** enrolled in one of the above means tested programs (food stamps, WIC, Energy Assistance, or reduced cost or free lunch), in addition to this application, please provide the following proof(s) of income **for the past twelve months**:

1) The most recent paycheck stub(s) from all jobs reflecting your year to date gross earnings.
2) If a paycheck voucher is unavailable, a letter on company letterhead, signed by the employer reflecting dates of employment and gross year to date income.
3) Your current year's Federal tax return (1040), if a business is owned, your schedule "C" from your 1040 must also be included and a year-to-date profit and loss report. If you did not file a tax return, please provide a signed letter stating the reason no tax return was filed and provide proof of all income for anyone living in the household, including unrelated members.
4) Proof of income for all individuals filed as an exemption on your current federal income tax return.
5) If your income comes from a source other than employment, such as unemployment, social security, disability, retirement, pension, veteran's benefits, child support, alimony, etc. you will need to provide proof.

If the required documents are not submitted with the application, the application will not be processed and it will be returned to you. Atlantic General Hospital will only accept applications with the required documents attached.

Please return your completed financial assistance application and the required documents to Outpatient Registration, Cashier's Office, Atlantic Health Center, Patient Accounting or mail it to:

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

You may be denied financial assistance if:

1) You do not meet the financial assistance income guidelines.
2) The application is not completed properly including your signature and date completed.
3) Supporting documentation (such as proof of income) is not returned within 14 days from the date of application.

If your Financial Assistance application is denied, you will be responsible for your bill.
If you have any questions, please call us at (410) 629-6025. Thank you.

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

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 completed application with documentation to:
Atlantic General Hospital
Attn: Financial Assistance, Box 10
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Berlin, MD 21811

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 _____
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