MARYLAND STATE UNIFORM ASSISTANCE APPLICATION

Information About You:

Name____
First Middle Last

Social Security #_______-_____-_______ Marital Status: single married separated divorced widowed

US Citizen: Yes No Permanent Resident Yes No

Home Address_________________________________ Phone_______________

____

____
City State Zip Code

Employer Name________________________________ Phone________________

Address______________________________________

____
City State Zip Code

Household Members (only members that you could claim on a tax return. **Please include yourself)**

Name	Date of Birth	Relationship

Have you applied for Medical Assistance in the state in which you live? ___________________
My Medical Assistance Application appointment is scheduled for ________________________
Do you receive any other type of state or county assistance? Yes No
Explain____

____

____

Garrett Regional Medical Center
251 North 4th Street
Oakland, MD 21550

Telephone 301-533-4209
Fax 301-533-4208

Please complete and sign the back side of this application………………………………..

Family Income

List the amount of your monthly income from all sources. ***YOU ARE REQUIRED*** to supply proof of income and assets. If you have no income you must request and complete a proof of no income form.

	His monthly	Her monthly
Employment **(Last Year's Tax return required)**	___________	_____________
Retirement / Pension Benefits	___________	_____________
Social Security Benefits	___________	_____________
Public Assistance Benefits	___________	_____________
Disability Benefits	___________	_____________
Unemployment Benefits	___________	_____________
Veteran's Benefits	___________	_____________
Alimony / Child Support	___________	_____________
Rental Property Income	___________	_____________
Military Allotment	___________	_____________
Farm or Self Employment	___________	_____________
Other income source (_________________)	___________	_____________

Liquid Assets	Current Balance
Checking account	___________________________
Savings Account	___________________________
Stocks, Bonds, CD, or Money Market	___________________________
Other Investments	___________________________

Other Assets

If you own any of the following items, please list the type and approximate current value.

Home: Year Financed_______ Loan term________ Approximate value_______________________

Automobile: Make_____________ Year ________ Approximate value_______________________

Automobile #2: Make__________ Year ________ Approximate value _______________________

Monthly Expenses (proof may be requested)

Rent / Mortgage	$________________	Medication	$__________________
Heat, Electric, Cable	$________________	Health Insurance	$__________________
Telephone/Cell	$________________	Doctor Bills	$__________________
Credit card	$________________	Other Hospital	$__________________
Car Payment	$________________	Medical Equip Rentals	$__________________
Car Insurance	$________________	Day Care	$__________________
Gasoline	$________________	Child Support	$__________________
Life Insurance	$________________	Food	$__________________
Homeowner Ins	$________________	Other_____________	$__________________

By signing this form, I certify that the information provided is true and agree to notify the hospital of any changes to the information within ten days of the change. By signing this, I am authorizing the use or disclosure of my financial assistance application for future approval in financial assistance programs offered by the hospital, West Virginia University Medicine, or any of their affiliates, if eligible. If I request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination.

This Application shall expire one year from the date set forth below.

Applicant's Signature_______________________________________ Date________________________