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
Name	Date of Birth	Relationship
Name	Date of Birth	Relationship
Name	Date of Birth	Relationship
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 301-533-4159 or 301-533-4179
Fax 301-533-4153

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 **Copy of most recent federal tax return (Preferred)**		
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_____