WVU Medicine
GARRETT REGIONAL MEDICAL CENTER

MRN: _____ DUE: _____

Dear Sir/Madam:

Garrett Regional Medical Center (GRMC) is pleased to offer financial assistance to individuals of our community who may need help with payment of charges for medical services obtained at GRMC regardless of whether you do or do not have insurance.

The following information is **required** to determine your eligibility:

1. Your Medical Assistance status:

   To apply for Medicaid of Maryland call (855) 642-8572 or go online at https://www.marylandhealthconnection.gov

   You may also contact either Social Services at (301) 533-3000 (aged, blind, disabled) or Healthy Families at (301) 334-7720.

   Out of State patients may contact their local health department.

2. Your Proof of Income (all that apply):
   - If you are on a fixed monthly income, please include a copy of your Award Letter.
   - If you filed taxes, copies of your Federal Income Tax return for the current year.
   - If you are Self Employed, please include a copy of your current Federal Income Tax form 1040 (with appropriate schedules attached).
   - If you are unemployed, please include a copy of your initial Award Letter or Webcert information.
   - Those who are eligible for the following programs will receive free care at 100% participation, unless otherwise eligible for Medicaid or CHIP. Proof of participation in the programs listed below is required.
     - Household with children enrolled in a free and reduced- cost meal program.
     - Supplemental Nutrition Assistance Program (SNAP)
     - State's Energy Assistance Program
     - Federal Special Supplemental Food Program for Women, Infants, and Children (WIC).
     - Any other social service program as determined by the Maryland Department of Health or Health Services Cost Review Commission.

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To save time processing your application, remember to only include household members, yourself, wife/husband, children or those claimed on your Federal Income Tax form and return within 30 days. Be sure to complete the application in full (front and back) as well as sign and date the application.

Once your application is received, please allow 7-10 business days for processing. You will receive a letter indicating your Caring Program Application status.

If you have any additional questions about the completion of the financial assistance process, do not hesitate to contact me at the number below.

NOTE: Your application cannot be processed without your proof of income for and a Medicaid denial letter.

Please feel free to contact GRMC Financial Assistance with any questions:

GRMC: 301-533-4000

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

Employee 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 where 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 Fourth 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 Assest

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

Home: Year Financed_____ Loan Term_____ Approximate Value_____

Automoblie: Make_____ Year _____ Approximate Value_____

Automoblie #2: Make_____ Year _____ Approximate Value_____

Monthly Expenses (proof may be requested)

Rental/ 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 Insureance	$_____	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 Univeristy 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_____