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 _____

_____

_____ _____
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 state or County Assistance? Yes No

Mail application to: TidalHealth Peninsula Regional – Patient Accounts
100 East Carroll Street
Salisbury, MD 21801

Name: _____
First Middle Last

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. Monthly Expense

	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 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 10 days.

Applicant signature _____ Date _____

Relationship to patient _____