WESTERN MARYLAND HEALTH SYSTEM

Caring for What Matters Most

Western Maryland Health System offers a Financial Assistance Program to patients who demonstrate they are unable to pay all or part of their medical bills. The WMHS program is based on the Federal Income Guidelines of the household, assets owned by the household and household size.

- Financial Assistance Program applications that are returned without all the required information **cannot** be processed
- Financial assistance will not be granted for motor vehicle accidents, workers' compensation or any third-party responsibility where patient requirements were not met

If additional information and/or documentation are required, we will contact you by phone or by mail within two (2) business days. You will be notified in writing of the decision regarding this application within 30 days of the receipt of the completed application. If you have any questions or concerns regarding your application, please contact a Financial Counselor at 240-964-8435 Monday – Friday between the hours of 7:30 a.m. and 4:00 p.m.

Please complete the entire application and return it with the required documentation to:

Willowbrook Office Complex
Attn: Patient Financial Services
P.O. Box 539
Cumberland, MD 21502

Sincerely,

Financial Counselor
Western Maryland Health System

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Checklist of information that MUST be attached to this financial application:

Financial Documentation

Please submit the following financial documentation to assist with processing your application. **A current income tax return is the preferred method for determining household income.**

___ Current income tax return form 1040 for previous calendar year (if business owner, Schedule C is required). If not returned, why? _____

___ Two current paystubs from employer for applicant and spouse. If not returned, why? _____

___ Bank statement for check/savings account on bank letterhead. If not returned, why? _____

___ Social Security, pension and/or disability

___ Unemployment amount received

___ Child support

___ Food stamps and any government assistance

If you have no income, please provide the following:

___ Signed letter of support detailing how living expenses are being met (signed by the person providing support)

Don't forget, have you:

___ Signed the application?

___ Completed the application

Please use this checklist so you do not forget any information that would cause your application to be denied. If you have any questions about the application and its process, please call **240-964-8435.**

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

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

Maryland State Uniform Financial Assistance Application

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	_____
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

Maryland State Uniform Financial Assistance Application

the hospital of any changes to the information provided within ten days of the change.

Applicant signature	Date
Relationship to Patient	

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Social Services Request Form

I, _____, have requested the assistance of Western Maryland Healthy System personnel to act on my behalf to obtain documentation of my participation in state/federal assistance programs, included but not limited to assistance from the Department of Social Services; SNAP, TANF, Medical Assistance, or other special programs. I therefore grant Western Maryland Health System personnel permission to request, receive and review my information as it pertains to eligibility for Financial Assistance offered by Western Maryland Health System.

_____ _____

SIGNATURE OF APPLICANT DATE

_____ _____

SIGNATURE OF WITNESS DATE

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Patient Authorization Form: Pharmacy Assistance Program

Please read and sign this authorization for the Patient Assistance Program. The information on this authorization will be used by Cardinal Health, acting as agent of Western Maryland Health System, to contact the drug manufacturing companies regarding your medications. All information will be kept in strict confidence.

Dear Patient:

Western Maryland Health System, in its mission to provide healthcare to persons of limited resources, often participates in programs that offer drugs and other therapies (i.e. stents, etc.) at no cost or at reduced prices for persons being treated for certain illnesses. The nature of your illness and the treatment prescribed for you may quality you for participation in one of the programs, such as the Pharmacy/Patient Assistance Program (PAP). The PAP may require that you disclose your financial status, illness and/or treatment to the drug manufacturing company sponsoring an assistance program. Your signature is required on certain forms that allow this disclosure. Once we disclose the health information, it may no longer be protected by privacy laws.

By signing this authorization, you authorize the reimbursement specialist(s) to sign any and all forms and applications on your behalf and to access and release any personal demographic, diagnostic, therapeutic and/or financial information required to apply for drug manufacturing company medication/PAP assistance programs.

Furthermore, by signing this letter, you attest that the information you have provided is true and accurate. This information will remain confidential within Western Maryland Healthy system and only be released to the drug manufacturing company sponsoring the program in compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and state law. In accordance with Western Maryland Health System policy, failure to complete application for all other sources for which you may be eligible will result in pharmacy benefits being denied or canceled. Signing this form does not release you from any financial responsibility to Western Maryland Health System including, but not limited to, pharmacy dispensing fees.

None of the following information and/or records will be included in the use and/or disclosure: HIV/AIDS-related information, mental health information, genetic testing information, drug/alcohol diagnosis, treatment or referral information.

I, _____, hereby give permission for the reimbursement specialist to sign on my behalf when seeking aid from drug manufacturing company Patient Assistance Programs. I understand that I may revoke this authorization at any time by contacting the Western Maryland Health System PAP office at 240-964-1465.

Please print:

First Name: _____ Middle Initial: _____ Last Name:_____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone Number : _____ Alternate Phone Number: _____

Signature of Patient or Guardian: _____ Date: _____