Uniform
Financial Assistance Application

Information about you

Name: ____
First Middle Last

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

Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of your income. 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	____________

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 ____