Uniform Financial Assistance Application

Information about you

Name:						
First	Middle			Last		
Home address _						
	ity State		Zip co	de	-	Country
Employer name	-				Phone	
Work address						
	City State		Z	Ip code		
Household mem	bers:					
Name		-	Date of Birth	Relations	hip	
Name		_	Date of Birth	Relations	hip	
Name		-	Date of Birth	Relations	hip	
Name		_	Date of Birth	Relations	hip	
Name		-	Date of Birth	Relations	hip	
Name		_	Date of Birth	Relations	hip	
Name		_	Date of Birth	Relations	hip	
Have you applied for Medical Assistance? Yes If yes, what was the date you applied? If yes, what was the determination						
Do you receive a	any state or County Assistan	ce?	Yes No			
Mail application to: TidalHealth Peninsula Regional – Patient Accounts 100 East Carroll Street Salisbury, MD 21801						

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 p	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	