

## *Anne Arundel Diagnostic Financial Assistance Application*

### *Information About You*

Name \_\_\_\_\_  
First Middle Last

Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 US Citizen:    Yes    No

Marital Status:    Single    Married    Separated  
 Permanent Resident:    Yes    No  
 Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

Phone \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
City                      State                      Zip code

\_\_\_\_\_  
Country

Employer Name \_\_\_\_\_

Phone \_\_\_\_\_

Work Address \_\_\_\_\_

\_\_\_\_\_  
City                      State                      Zip code

**Household members:**

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
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

### ***I. Family Income***

List the amount of your monthly income from all sources. Please attach last years W2 form. 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	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Other income source	_____
<b>Total</b>	_____

### ***II. Liquid Assets (Attach Last Bank Statement)***

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
<b>Total</b>	_____

### ***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 _____
<b>Total</b>		_____

### ***IV. Monthly Expenses***

	Amount
Rent or Mortgage	_____
Utilities	_____
<b>Total</b>	_____

Do you have any other unpaid medical bills at Anne Arundel Health System?

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

\_\_\_\_\_  
 Applicant signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

Anne Arundel Diagnostics  
 Attention: Darlene Facciani  
 600 Ridgely Avenue, Suite 110  
 Annapolis, Maryland 21401

