Please choose service:	
Dental Practice	☐
Family Practice	☐
Both	☐

FAMILY HEALTHCARE OF HAGERSTOWN

201 S. Cleveland Ave, Hagerstown, MD 21740

Family Healthcare of Hagerstown has adopted a Financial Assistance Program for all patients regardless of inability to pay. We offer a Sliding Fee Discount based on family size and total family income. The current maximum income per family may be obtained by calling the Outreach/Enrollment Counselor at 301-393-3467.

Please completely fill out both sides of this application, sign the form and return with the required documents to:

Family Healthcare of Hagerstown
Attention: Outreach/Enrollment Counselor
201 S. Cleveland Ave
Hagerstown, MD 21740

Please note that the information provided on this application is valid for up to one year. Patients are responsible for completing a new application prior to the expiration of there current application.

Patient's Name _____ Date of Birth _____

Street Address _____ S. S. No. _____

City _____ State _____ Zip _____ Home/Cell Phone # _____

How long at this address? _____ Number living in household _____

List Names of Household Members: Relationship
(Please indicate which household member is a Dependent. Dependent is defined as someone who is listed on your Federal Income tax form)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Marital Status: __ Married __ Single __ Divorced __ Separated __ Widowed

Patient's Place of Employment _____ How long employed there? _____

Spouse's/Other Employment _____ How long employed there? _____

Other Employment _____

Are you unemployed? ___ Yes ___ No If yes, are you receiving unemployment income? ___ Yes ___ No
If Yes, What State are you receiving unemployment benefits? __MD, __PA, ___WV
Are you eligible for Medical Assistance? ___ Yes ___ No You could be eligible if you are: disabled, have children in the family under the age of 18, or pregnant.
If yes, have you applied for Medical Assistance? ___ Yes ___ No If Yes, what State ____MD,____PA,____WV
If yes, what was the outcome? ___ Approved ___ Denied If denied within the last 90 days, attach a copy of the denial letter.
Medicaid ID# _____

BE SURE TO COMPLETE BOTH SIDES OF FORM

Home Status:

__ Own Monthly Mortgage Payment Amount $_____ Balance Owed $_____
__ Rent Monthly Rental Payment Amount $ _____
__ Housing Assistance with Rent __ Yes __ No Amount Received $ _____
Do you live in: ( )Public, ( )Section 8. ( )HUD, ( )Private Housing

Other Monthly Bills:

Electric	Payment Amount $_____	Credit Card	Payment Amount $_____
Heat	Payment Amount $_____	Credit Card	Payment Amount $_____
Telephone	Payment Amount $_____	Loans-Personal	Payment Amount $_____
Cable	Payment Amount $_____	Other Debt	Payment Amount $_____
Gas	Payment Amount $_____	Other Debt	Payment Amount $_____
Vehicle	Payment Amount $_____	Make _____	Model _____ Year _____
Vehicle(2nd)	Payment Amount $_____	Make _____	Model _____ Year _____

Gross Monthly Salary $_____ Spouse's/Other's Income $_____

Gross Monthly Salary $_____ Social Security $_____

Unemployment $_____ Disability $_____

Other Income $_____ Child Support $_____

Investment Income $_____ Pension $_____

Total Yearly Family Income $_____

***Proof of Income Is Required. Application will not be processed unless documents below are provided:**

_____ Past 30 days pay stubs
_____ Unemployment compensation statements
_____ Pensions statements
_____ Disability statements
_____ Child support statements
_____ Alimony statements
_____ Social Security statements
_____ Self-employment earnings for business
_____ Current signed 1040 Federal Income Tax Form Did not File Taxes ___
_____ If no income, explanation of how living expenses are paid. If someone else is assisting you, they will need to write a statement. **Statement must include** signature of person making statement, date, and phone number where they can be reached.

I swear or affirm under penalty of perjury, that all information I gave is true, accurate and complete to the best of my ability, belief, and knowledge. I also authorize Family Healthcare of Hagerstown (FHH) or any other investigative agency employed by FHH to contact any person, partnership, corporation, association, or governmental agency that knows the facts about my eligibility and for those parties to give that information to FHH.

Signature of Applicant _____ Date _____

I authorize FHH to forward financial information provided by me and obtained from other organizations to Meritus Medical Laboratory and/or Quest Diagnostics to determine eligibility for their assistance program.

Signature of Applicant _____ Date _____

To Be Completed by FHH – Do Not Write Below This Line

Received by _____ Date _____

Approved by _____ Date _____ Percentage _____%

Period Approved _____ to _____