

Please choose service:

Dental Practice

Family Practice

Both



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 their 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, Medicaid ID# _____ attach a copy of the denial letter.

BE SURE TO COMPLETE BOTH SIDES OF FORM

Walnut Street Community Health Center, Inc. does business as Family Healthcare of Hagerstown (FHH). This health center receives funding through Health and Human Services (HHS) and is a grantee under 42 U.S.C. 254b. FHH has Federal Public Health Services (PHS) deemed status related to certain health or health-related claims under 42 U.S.C. 233(g)-(n). This includes medical malpractice claims for itself and its covered individuals. FHH is a nonprofit organization under section 501(c)3 of the IRS Code. This institution is an equal opportunity provider and employer.

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 _____