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

BE SURE TO COMPLETE BOTH SIDES OF FORM

Income Status:

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 certify that the information provided on this application is true and complete and may be checked for accuracy. I understand that willful falsification and/or omission of information contained in this application will result in denial of financial assistance.

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 _____ Category _____

Period Approved _____ to _____ FP/MH Fee _____
Dental Fee _____/_____
Insurance_____

Revised 8/2019