Patient Name: _____
Patient #: _____

FINANCIAL APPLICATION

Information About You IP ___ OP ___ PHP ___

Name _____

Last First Middle

Social Security Number: _____ - ____ - _____ Marital Status: Single / Married / Separated

US Citizen: Y / N Permanent Resident: Y / N

Home Address: _____ Phone: (_____) _____ - _____

_____ County: _____

City: _____ State: _____ Zip Code: _____

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: _____

Have you applied for Medical Assistance? Y / N

If yes, what was the date you applied? _____

If yes, what was the determination? _____

Do you receive any type of state or county assistance? Y / N

Hospital Name: Brook Lane
Return Address: P.O. Box 1945
Hagerstown, MD 21742
Attn: Angela Duffey
angie.duffey@brooklane.org

I. **Family Income**

List the amount of your monthly Income from all sources. If you have no Income, please provide a letter of support from the person providing your housing and meals. Additional information may be requested after receipt of application.

Monthly Income (attach last 2 paystubs)

NEED PROOF OF INCOME

	NET	**GROSS**
Employment		
Retirement/pension benefits		
Social Security benefits		
Public Assistance benefits		
Disability benefits		
Unemployment benefits		
Veterans' benefits		
Alimony		
Rental Property Income		
Military allotment		
Farm or self-employment		
Other Income source		
	NET	**GROSS**

TOTAL: _____ **FPL**: _____

II. **Liquid Assets**

Checking account _____

Savings account _____

Stocks, bonds, CD, or money market _____

Other accounts _____

TOTAL _____

III. **Other Assets**

If you own any of the following items, please list the type and approximate value.

Home Loan Balance _____ Approx. Value _____

Automobile Make _____ Approx. Value _____

Additional Vehicle Make _____ Approx. Value _____

Other Property Approx. Value _____

TOTAL _____

IV. **Monthly Expenses**

	Amount		Amount
Rent or Mortgage	_____	Car Insurance	_____
Utilities	_____	Health Insurance (If not deducted from payroll check)	
Car Payment	_____		_____
Credit Card(s)	_____ _____	Other Medical Expenses	_____ _____
	Monthly Payments Total Balance Due		

Other Expenses _____ _____ _____ _____ _____ _____ = _____

Expense Amount Expense Amount Expense Amount Total other expenses

TOTAL _____

TOTAL INCOME _____ TOTAL EXPENSES _____ DIFFERENCE _____

revised 11/04/2021 amd

COMMENTS:

_____

_____

_____

_____

**BY SIGNING THIS FORM, YOU CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND AGREE TO NOTIFY BROOK LANE OF ANY CHANGES TO THE INFORMATION PROVIDED WITHIN 10 DAYS OF THE CHANGE:

Signature: _____ Date: _____

Signature: _____ Date: _____

TO BE COMPLETED BY DIRECTOR OF PATIENT ACCOUNTS

DECISION: **INSURANCE PAYMENT** _____

SELF-PAY _____

FINANCIAL ASSISTANCE _____

START DATE: _____ **EXPIRATION DATE**_____

SIGNATURE: _____ **DIRECTOR OF PATIENT ACCOUNTS**

DATE: _____

COMMENTS:

_____

_____

_____

_____

_____