Anne Arundel
Diagnostics Imaging

Anne Arundel Diagnostic Imaging 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

Anne Arundel Diagnostics Imaging

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	______________
Total	______________

II. Liquid Assets (Attach Last Bank Statement)

	Current Balance
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 ________________		Approximate value ______________
Automobile	Make _________	Year ______	Approximate value ______________
Additional vehicle	Make _________	Year ______	Approximate value ______________
Additional vehicle	Make _________	Year ______	Approximate value ______________
Other property			Approximate value ______________
		Total	______________

IV. Monthly Expenses

	Amount
Rent or Mortgage	______________
Utilities	______________
Total	______________

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 Imaging
Attention: Darlene Facciani, Business Operations Coordinator
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Annapolis, Maryland 21401
443-481-4915