UPMC LIFE CHANGING MEDICINE

UPMC Western Maryland offers a Financial Assistance Program to patients who demonstrate they are unable to pay all or part of their medical bills. The UPMC Western Maryland program is based on the Federal Income Guidelines of the household, assets owned by the household and household size.

- Financial Assistance Program applications that are returned without all the required information **cannot** be processed
- Financial assistance will not be granted for motor vehicle accidents, workers' compensation or any third-party responsibility where patient requirements were not met

If additional information and/or documentation are required, we will contact you by phone or by mail within two (2) business days. You will be notified in writing of the decision regarding this application within 30 days of the receipt of the completed application. If you have any questions or concerns regarding your application, please contact a Financial Counselor at 240-964-8435 Monday – Friday between the hours of 7:30 a.m. and 4:00 p.m.

The Health Service Cost Review Commission establishes a process for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of 19-214.1 or 19-214.2 of this subtitle. The email address for the Health Service Cost Review Commission patient complaint hscrc.patient-complaints@maryland.gov. Additionally, complaints can be made jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office: 200 St. Paul Place, Baltimore, MD 21202 www.marylandattorneygeneral.gov

Please complete the entire application and return it with the required documentation to:

UPMC Western Maryland
Attn: Patient Financial Services
12501 Willowbrook Road
Cumberland, MD 21502

Sincerely,

Financial Counselor
UPMC Western Maryland

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Checklist of information that MUST be attached to this financial application:

Financial Documentation

Please submit the following financial documentation to assist with processing your application. **A current income tax return is the preferred method for determining household income.**

___Current income tax return form 1040 for previous calendar year (if business owner, Schedule C is required). If not returned, why? _____

___Two current paystubs from employer for applicant and spouse. If not returned, why?
_____

___Bank statement for check/savings account on bank letterhead. If not returned, why?
_____

___Social Security, pension and/or disability

___Unemployment amount received

___Child support

___Food stamps and any government assistance

If you have no income, please provide the following:

___Signed letter of support detailing how living expenses are being met (signed by the person providing support)

Don't forget, have you:

___Signed the application?

___Completed the application

Please use this checklist so you do not forget any information that would cause your application to be denied. If you have any questions about the application and its process, please call **240-964-8435.**

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number _____ _____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

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

_____ _____ _____
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

Maryland State Uniform Financial Assistance Application

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. 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	
Public assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self employment	
Other income source	
Total	

II. Liquid Assets

	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	
Car payment(s)	
Credit card(s)	
Car insurance	
Health insurance	
Other medical expenses	
Other expenses	
Total	

Do you have any other unpaid medical bills? 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

Maryland State Uniform Financial Assistance Application

the hospital of any changes to the information provided within ten days of the change.

Applicant signature

Date

Relationship to Patient

UPMC LIFE CHANGING MEDICINE

Social Services Request Form

I, _____, have requested the assistance of UPMC Western Maryland personnel to act on my behalf to obtain documentation of my participation in state/federal assistance programs, included but not limited to assistance from the Department of Social Services; SNAP, TANF, Medical Assistance, or other special programs. I therefore grant UPMC Western Maryland personnel permission to request, receive and review my information as it pertains to eligibility for Financial Assistance offered by UPMC Western Maryland.

_____ _____

SIGNATURE OF APPLICANT DATE

_____ _____

SIGNATURE OF WITNESS DATE

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Patient Authorization Form: Pharmacy Assistance Program

Please read and sign this authorization for the Patient Assistance Program. The information on this authorization will be used by Cardinal Health, acting as agent of UPMC Western Maryland, to contact the drug manufacturing companies regarding your medications. All information will be kept in strict confidence.

Dear Patient:

UPMC Western Maryland, in its mission to provide healthcare to persons of limited resources, often participates in programs that offer drugs and other therapies (i.e. stents, etc.) at no cost or at reduced prices for persons being treated for certain illnesses. The nature of your illness and the treatment prescribed for you may quality you for participation in one of the programs, such as the Pharmacy/Patient Assistance Program (PAP). The PAP may require that you disclose your financial status, illness and/or treatment to the drug manufacturing company sponsoring an assistance program. Your signature is required on certain forms that allow this disclosure. Once we disclose the health information, it may no longer be protected by privacy laws.

By signing this authorization, you authorize the reimbursement specialist(s) to sign any and all forms and applications on your behalf and to access and release any personal demographic, diagnostic, therapeutic and/or financial information required to apply for drug manufacturing company medication/PAP assistance programs.

Furthermore, by signing this letter, you attest that the information you have provided is true and accurate. This information will remain confidential within UPMC Western Maryland and only be released to the drug manufacturing company sponsoring the program in compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and state law. In accordance with UPMC Western Maryland policy, failure to complete application for all other sources for which you may be eligible will result in pharmacy benefits being denied or canceled. Signing this form does not release you from any financial responsibility to UPMC Western Maryland including, but not limited to, pharmacy dispensing fees.

None of the following information and/or records will be included in the use and/or disclosure: HIV/AIDS-related information, mental health information, genetic testing information, drug/alcohol diagnosis, treatment or referral information.

I, _____, hereby give permission for the reimbursement specialist to sign on my behalf when seeking aid from drug manufacturing company Patient Assistance Programs. I understand that I may revoke this authorization at any time by contacting the UPMC Western Maryland PAP office at 240-964-1465.

Please print:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone Number : _____ Alternate Phone Number: _____

Signature of Patient or Guardian: _____ Date: _____