ST. MARY'S COUNTY HEALTH DEPARTMENT
Meenakshi G. Brewster, MD, MPH - Health Officer

Administration, Records & Health Services: 301 – 475 – 4330
Environmental Health: 301 – 475 – 4321
Medical Assistance Transportation: 301 – 475 – 4296
Maryland Relay Service: 1 – 800 – 735 – 2258
Email: smchd.healthdept@maryland.gov

Financial Aid Application Form

First/Middle/Last Name:_____ **Date of Birth:**_____

Mailing Address:_____

# of Household Members:

Name	Age	Relationship

Household Income- List income from your and your spouse/partner (if applicable). If you have no income, indicate that below.

Income Source	Annual Amount
Employment	
Other Income Sources	
Total	

Have you applied for Medical Assistance: Yes / No
Would you like assistance applying for Medical Assistance Yes / No

In addition to the Sliding Fee Scale Program, St. Mary's County Health Department clients may apply for a payment plan and/or additional fee waiver due to financial hardship or inability to pay. Please indicate which assistance you are interested in:

Income Based Sliding Fee Scale Yes / No
Payment Plan Yes / No
Additional Fee Waiver Yes / No

My signature confirms that all information provided is true and complete to the best of my ability, belief and knowledge.

Applicant Signature:_____ **Date:** _____

Clients will receive a determination letter via U.S. mail indicating the amount and duration of discount approved.

To be completed by Fiscal Office

Fiscal Office Recommendation (Check all that apply)

_____ Sliding Fee Scale Program
_____ Additional Fee Waiver
Total Fees to be Waived_____
_____ Payment Plan
Agreed Upon Schedule _____

Financial Assistance Applicable Dates:

From: _____ To: _____

Approval letter sent to client and uploaded in CureMD? Yes / No

Chief Fiscal Officer Signature: _____ Date: _____

Health Officer Signature ***Required for additional fee waiver approval**

_____ Date: _____