

FINANCE



JOHNS HOPKINS
M E D I C I N E

**Johns Hopkins Medicine
Financial Assistance Application**

Please complete the attached forms and return them along with the documentation as indicated below.

Forms to include:

Maryland State Uniform Financial Assistance Application (attached)

Documentation to include:

1. Copy of last year's tax returns. (If married and filed separately, please provide copies of both returns).
2. Copy of your last three (3) pay stubs, letter from employer or proof of unemployment status.
1. Copy of social security award letter (if applicable)
2. Copy of the determination letter from Medical Assistance or Social Security.
3. Proof of monthly living expenses as recorded on your application such as copies of phone bills, BG&E bills, or rent/mortgage payments.
4. Copies of unpaid medical expenses.
5. Copy of all medical insurance cards.
6. Proof of residence such as an identification card, driver's license, birth certificate or lawful permanent residence status (green card).

**PLEASE MAIL INFORMATION TO:
JOHNS HOPKINS RCM
3910 KESWICK ROAD, SUITE S-5100
ATTN: FINANCIAL ASSISTANCE LIASON
BALTIMORE, MD 21211**

	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 Benefits	_____
Farm or Self Employment	_____
Other Income Source	_____
Total	_____

<i>II. Liquid Assets</i>	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	_____

Do you have any other unpaid medical bills? YES NO
For what service? _____
If you have arranged a payment plan? What are the monthly payments? _____

For Medical Financial Hardship Assistance Eligibility:
Family Income for twelve (12) calendar months preceding date of this application: _____

Medical Debt incurred at Johns Hopkins (not including co-insurance, co-payments, or deductibles) for the twelve (12) calendar months preceding the date of this application:

Date of Service	Amount owed
_____	_____
_____	_____
_____	_____
_____	_____

For Presumptive Financial Assistance Eligibility:

- | | |
|---|-----------|
| 1. What is the patient's age? | _____ |
| 2. Is patient pregnant? | Yes or No |
| 3. Does patient have children under 21 years of age living at home? | Yes or No |
| 4. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? | Yes or No |
| 5. Is patient currently receiving SSI or SSDI benefits? | Yes or No |
| 6. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the follow amounts? | Yes or No |

Family Size:

Individual: \$2,500.00

Two people: \$3,000.00

For each additional family member, add \$100.00

(Example: For a family of four, if you have total liquid assets of less than \$3,200.00, you would answer, YES.)

- | | |
|---|--------------------|
| 7. Is patient a resident of the State of Maryland?
If not a Maryland resident, in what state does patient reside? | Yes or No
_____ |
| 8. Is patient homeless? | Yes or No |
| 9. Does patient participate in WIC? | Yes or No |
| 10. Does household have children in the free or reduced lunch program? | Yes or No |
| 11. Does household participate in low-income energy assistance program? | Yes or No |
| 12. Does patient receive SNAP/Food Stamps? | Yes or No |
| 13. Is the patient enrolled in Healthy Howard, Chase Brexton? | Yes or No |
| 14. Was patient referred to SH by Catholic Charities, Mobile Med, Montg Co Cancer Crusade, Primary Care Coalition, Montgomery Cares, Project Access, or Proyecto Salud? | Yes or No |
| 15. Does patient currently have:
Medical Assistance Pharmacy Only | Yes or No |
| QMB/SMLB | Yes or No |
| 16. Is patient employed?
If no, date became unemployed. | Yes or No |
| Eligible for COBRA health insurance coverage? | Yes or No |

All documentation submitted becomes part of this application.

If you request that you be extended additional financial assistance, JHM 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 JHM of any changes to the information provided within ten days of the change. All the information submitted in the application is true and accurate to the best of my knowledge, information and belief.

Applicant Signature

Date

Relationship to Patient