CARDIOVASCULAR SPECIALISTS OF CENTRAL MARYLAND
2016 FINANCIAL ASSISTANCE APPLICATION
Please complete ALL SECTIONS and PRINT all information clearly.

OFFICE USE ONLY

PLEASE READ THIS SECTION BEFORE COMPLETING THIS APPLICATION:

Cardiovascular Specialists of Central Maryland provides reduced-cost or free care to low-income patients who lack health insurance coverage for medical services, or to those patients who are financially unable to pay their coinsurance or deductible amounts under their health insurance plan. Financial assistance reductions are determined based on applicants' gross income and current Federal Poverty Guidelines. **Patients must have exhausted all potential health insurance coverage options or available benefits, including applying for Medical Assistance, to be considered for reduced-cost or free care services**.

IMPORTANT: You MUST attach the following supporting documentation to this Application, or it will be DENIED. A temporary hold has been placed on your account, but if this application is not returned within 30 days, your account may be subject to further collection action if it is past due. Account balances placed for outside collection ARE NOT eligible for financial assistance reductions.

DOCUMENTATION REQUIRED FOR ALL APPLICANTS:

1. Copy of a **valid photo ID** (such as a driver's license with photograph, state non-driver's ID with photograph, passport, etc.) and copies of all **health insurance cards**, if applicable.
2. Copies of the last three pay stubs for all adults in the household. If any adult in the household is unemployed, copies of all unemployment insurance award letters even if not currently receiving unemployment insurance benefits.
3. Copy of the determination/award letter(s) from Medical Assistance and/or Social Security.
4. Proof of **any other income** listed on this application or documentation of **who is paying your expenses** if you are claiming no source of income.

Documentation submitted with this application becomes part of your file and WILL NOT be returned to you. If you cannot make copies of these documents, please **BRING** the originals to our office and we will make copies. **DO NOT MAIL ORIGINAL DOCUMENTS TO US.** Please return your completed Financial Assistance Application and supporting documentation to:

Cardiovascular Specialists of Central Maryland
Attn: BUSINESS OFFICE
10710 Charter Drive, Suite 400
Columbia MD 21044

INFORMATION ABOUT YOU:

LAST Name/SURNAME **FIRST/GIVEN Name** **Middle Initial**

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐ Date of Birth: ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)

Martial Status ☐ Single ☐ Married ☐ Separated ☐ Divorced

Are you a U.S. Citizen? ☐ Yes ☐ No If not a U.S. Citizen, are you a Permanent Resident? ☐ Yes ☐ No

Do you have a primary care physician? ☐ Yes ☐ No If yes, who is it? ____________

Home Address
(Street)
(Apt No.)
(City, State, Zip)

Home Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐ Cell Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

PLEASE COMPLETE ALL APPLICABLE SECTIONS AND SIGN ON PAGE 3 TO AVOID DELAYS IN PROCESSING.

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Patient Name ____________________

INFORMATION ABOUT YOU (continued):

Are You Employed? ☐ Yes ☐ No ☐ Self-Employed Work Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Your Employer	(Company)
Work Address	(Street)
	(City, State, Zip)

Do you have health insurance? ☐ Yes ☐ No If yes, what insurance company? ____________________

If yes, name of policyholder ____________________ Insurance ID # ____________________

INFORMATION ABOUT THE OTHER PEOPLE WHO LIVE IN YOUR HOUSEHOLD:

Is Your Spouse Employed? ☐ Yes ☐ No ☐ Self-Employed ☐ N/A Work Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Spouse's Employer	(Company)
Work Address	(Street)
	(City, State, Zip)

How many people AGE 18 OR OLDER live in your household, including you? ____________________

How many people age UNDER AGE 18 live in your household? ____________________

Please list ALL people over age 18 who live with you, regardless of age or relationship.

NAME	AGE	RELATIONSHIP TO YOU

INFORMATION ABOUT FINANCIAL OR OTHER ASSISTANCE YOU RECEIVE:

Have you applied for Medical Assistance? ☐ Yes ☐ No If yes, when did you apply? ☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

If yes, what was the determination? ☐ Approved ☐ Denied **Please attach a copy of the determination letter.**

Do you receive any other type of GOVERNMENT or PRIVATE financial or medical assistance, including assistance from FAMILY MEMBERS? ☐ Yes ☐ No

If yes, please describe: ____________________

Have you been approved for financial assistance by Howard County General Hospital or by Johns Hopkins Hospital? ☐ Yes ☐ No ☐ N/A

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Patient Name

INFORMATION ABOUT YOUR HOUSEHOLD INCOME:

STOP : If you have been APPROVED for financial assistance from Howard County General Hospital and/or from Johns Hopkins Hospital in the last 90 days, please ATTACH A COPY OF THE AWARD LETTER(S), then SIGN and DATE the application below and return it to our office. You DO NOT have to submit proof of income with this application if you have been approved for financial assistance by Howard County General Hospital or Johns Hopkins Hospital ONLY.

List the amount of your MONTHLY GROSS income from all sources. You are required to supply PROOF OF ALL INCOME.

If you claim NO income, please provide a letter from the person providing your housing, meals and any other support.

If you have no spouse, but there are other adults in your household, list their income under Spouse/Other Adults Income.

Income Source	Your Monthly GROSS Income (before taxes)	Other Adult(s) Monthly GROSS Income
Employment From a Job (work for a person or company)	$	$
Self Employment Income (work for yourself)	$	$
Retirement or Pension Benefits	$	$
Social Security Benefits - attach copy of benefit statement	$	$
Public Assistance Benefits - attach copy of benefit statement	$	$
Disability Benefits - attach copy of benefit statement	$	$
Unemployment Benefits - attach copy of award letter	$	$
Alimony or Child Support - attach copy of court order	$	$
Other Income (Describe)	$	$
TOTAL	$	$

APPLICATION CERTIFICATION AND SIGNATURE:

We may request additional information and/or documentation in order to make a decision about extending financial assistance to you for your bills with Cardiovascular Specialists of Central Maryland.

By signing this form, you certify that the information provided is true and you agree to notify us of any changes to the information you have given us within ten (10) days of when the information changes.

Applicant Signature ____________________ Date ____________________

Applicant PRINTED Name ____________________ Relationship (if Applicant is not Patient) ____________________

*** DO NOT WRITE BELOW THIS LINE ***

FOR OFFICE USE ONLY:	Date Given By / /	Date Received By / /	Date Processed By / /

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