CARDIOVASCULAR SPECIALISTS OF CENTRAL MARYLAND

A Member of Johns Hopkins Regional Physicians

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 that have been placed for outside collection ARE NOT eligible for financial assistance reductions.***

DOCUMENTATION REQUIRED FOR ALL APPLICANTS:

1. 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.
2. Copy of the **determination/award letter(s)** from Medical Assistance and/or Social Security if you receive these benefits.
3. Proof of **any and all 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**

Social Security Number (Last 4): X X X - X X - _ _ _ _ Date of Birth: _ _ - _ _ - _ _ _ _ (M M - D D - Y Y Y Y)

Are You Currently: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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? ☐ No ☐ YES 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.

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:

If married, is your spouse employed? ☐ Yes ☐ No ☐ Self-Employed ☐ N/A Work Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

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

Besides you, is there AGE 18 OR OVER in your household? ☐ No ☐ Yes If yes, how many? ☐

Is there anyone UNDER AGE 18 in your household? ☐ No ☐ Yes If yes, how many? ☐

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

CARDIOVASCULAR SPECIALISTS OF CENTRAL MARYLAND
A Member of Johns Hopkins Regional Physicians
FINANCIAL ASSISTANCE APPLICATION

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. Otherwise, please complete the rest of this section.***

1. List the amount of your MONTHLY GROSS income from all sources. You are required to supply PROOF OF ALL INCOME.
2. If you claim NO income, please provide a letter from the person providing your housing, meals and any other support.
3. 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)	Monthly GROSS Income for Other Adult(s)
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 - attach copy of benefit statement	$	$
Disability Benefits - attach copy of benefit statement	$	$
Unemployment Benefits - attach copy of award letter	$	$
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

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