FINANCE

JOHNS HOPKINS
MEDICINE

Johns Hopkins Medicine
Financial Assistance Application

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

Forms to include:

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:
3910 KESWICK ROAD, SUITE S-5100
ATTN: FINANCIAL ASSISTANCE LIASON
BALTIMORE, MD 21211

FINANCE

JOHNS HOPKINS
MEDICINE

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 Country

Employer Name: _____ Phone _____
Work Address: _____

_____
City State Zip

Household Members:

		SELF
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

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 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 Benefits	
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	

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? Yes or No
If not a Maryland resident, in what state does patient reside? _____

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? Yes or No
If no, date became unemployed. _____
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