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

Forms to include:
Financial Assistance Application (included)

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.
3. Copy of current year Social Security award letter (if applicable).
4. Copy of determination letter from Medical Assistance or Social Security.
5. Proof of monthly living expense as recorded on your application such as copies of phone bills, utility bills, or rent/mortgage payments.
7. Copy of all medical insurance cards.
8. Proof of residence such as an identification card, driver’s license, birth certificate or lawful permanent residence status (green card).
9. Copy of three most recent bank statements
10. If applicable, self-employed patients completed tax return (including profit or loss)
11. If applicable, zero income notarized letter of support written by the person providing financial support

MAILING ADDRESS:
Johns Hopkins Hospital
3910 Keswick Road, Suite S-5100
ATTN: Financial Assistance Liaison
Baltimore, MD 21211

EMAIL: FinancialAssistance@jhmi.edu

PHONE: 443-997-3067

FAX: 443-769-1250
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Age</td>
<td>Relationship</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Relationship</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Relationship</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Relationship</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Relationship</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Relationship</td>
</tr>
</tbody>
</table>

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.
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
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
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
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?  

3. Does patient have children under 21 years of age living at home?  

4. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment?  

5. Is patient currently receiving SSI or SSDI benefits?  

6. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the follow amounts?  

   **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?  

8. Is patient homeless?  

9. Does patient participate in WIC?  

10. Does household have children in the free or reduced lunch program?  

11. Does household participate in low-income energy assistance program?  

12. Does patient receive SNAP/Food Stamps?  

13. Is the patient enrolled in Healthy Howard, Chase Brexton?  

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?  

15. Does patient currently have:  
   - Medical Assistance Pharmacy Only  
   - QMB/SMLB  

16. Is patient employed?  

   If no, date became unemployed.  
   Eligible for COBRA health insurance coverage?  

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