Johns Hopkins Hospital
Johns Hopkins Bayview
Howard County General Hospital

Maryland State Uniform 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:

Name	Age	Relationship
_____	_____	**SELF**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, your certify that theinformation provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant Signature Date

_____

Relationship to Patient