CATHOLIC HEALTH INITIATIVES®

St. Joseph
Medical Center

Date: ______________________________

Name: ______________________________

Account #: ______________________________

St. Joseph Medical Center appreciates your interest in the Financial Assistance application process. This application should be completed and mailed back to St. Joseph's Business Office. The following items will need to be included with your application:

- Completed and signed Financial Assistance Application
- Proof of income for self and/or spouse (6 weeks of pay stubs)
- Bank statements (checking, savings, retirement)
- Most recent Federal Tax Return
- Award letters from Social Security Administration or Department of Social Services
- If any members of the household are enrolled in an assistance program such as Food Stamps, Cash Assistance, Medical Assistance/MCHP, P.A.C., School Lunch, Subsidized Housing, Energy Assistance or W.I.C. please provide a copy of the award letter
- Denial letter from the Maryland Medical Assistance Program (Medicaid)

Once we have received all of the above information, we will process your application. You can expect to receive a response within 30 days upon receipt of a completed application.

If you have any questions regarding the Financial Assistance application, please call St. Joseph's Business Office, 410.337.3902. Please be advised that all personal information shall remain confidential.

St. Joseph Medical Center
Business Office
7601 Osler Drive
Towson, MD 21204

# Maryland State Uniform
# Financial Assistance Application

*Information About You*

Name: ______________________________________________
First    Middle    Last

Social Security Number: ____ - ____ - ____    Martial Status: Single    Married    Separated
US Citizen: Yes No    Permanent Resident: Yes No

Home Address: ______________________________    Phone: ______________
______________________________
______________________________    ______________
City    State    Zip code    Country

Employer Name: ______________________________    Phone: ______________
Work Address: ______________________________
______________________________
City    State    Zip code

Household members:

| Name | Age | Relationship |
|---|---|---|
| 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

Hospital Name: ______________________________
Return Address: ______________________________

*I. Family Income*

List the amount of your monthly income from all sources. You may required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support 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 allotment | ____________ |
| 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 lits 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 | ____________ |
| **Total** | ____________ |

Do you have any other unpaid medical bills? Yes No

For what service? ______________________________

If you have arranged a payment plan, what is the monthly payment? ______________

If you request that the hospital extend additional financial assistance, the hospital may request additional information in oder to make a supplemental determination. By signing this form, you certify that the information 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