LEVINDALE
A LifeBridge Health Center

CARE BRAVELY

Date: _____ Account # _____

Patient Name: _____ Account #: _____

Dear: _____ Account #: _____

In order to determine your eligibility for financial assistance please complete the enclosed application and forward the following items:

1. The following is required as proof of income. Please provide proof of income for any household Members considered in this application process. **(Please check source of income)**
   - A. Two most recent pay stubs _____
   - B. Bank statement showing interest _____
   - C. Award letter, Social Security Administration, **(If Citizen of US)** _____
   - D. Award letter, pension fund _____
   - E. Award letter, Maryland Depart. Social Service, **(If resident of Maryland)** _____
   - F. Proof of unemployment compensation _____

2. Please provide copies of the following tax information
   - A. W-2 Forms
   - B. Previous year Tax Forms
   - C.

3. **If resident of Maryland** please provide denial letter from Maryland Medical Assistance Program.

4. **Notarized letter** stating you presently have no income *********

5. **Presumptive Eligibility** If you are a beneficiary/recipient of the following means-tested social services program, submit proof of enrollment with your application: households with children in the free or reduced lunch program; Supplemental Nutritional Assistance Program (SNAP); Low-income-household energy assistance program; Primary Adult Care Program (PAC); Women, Infants and Children (WIC). If you are eligible for any of the following means-tested Medicaid programs, submit eligibility identification with your application: Family Planning or Pharmacy Only Program(s); Qualified Medicare Beneficiary (QMB); Specified Low Income Medicare Beneficiary (SLMB); X02 Emergency Services Only. If you are eligible for any of the following other programs, please submit proof of eligibility with your application: State Grant Funded programs including Department of Vocational Rehabilitation (DVR), Intensive Outpatient Psychiatric Block Grant (IOP), Sinai Hospital Addiction Recovery Program (SHARP); Jewish Family Children Services (JFCS)>

   You must return the completed application and all applicable documents within 14 days of receipt. Your application will not be reviewed without the above information. Please return this letter with your application. Your personal information will be kept confidential. The Hospital's Financial Assistance Program covers hospital/facility charges only. Professional physician fees are not covered under this program.

   If you have further questions regarding this application, wish to appeal or make a complaint, please Contact Customer Service at 410-521-5959 Monday- Friday 7:30 a.m. – 5:00 p.m.

Please return to **Levindale Hebrew Geriatric Center and Hospital 2434 W Belvedere Avenue, Patient Financial Services Attention: Patient Accounting Baltimore, Maryland 21215**

Yours truly,

Patient Accounting
Customer Service

For Hospital / Department / Agency use only

Originator Name: _____

Department: _____ **Ext.** _____

Agency Name: _____

LEVINDALE
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CARE BRAVELY

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 Code County

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household members:

Name	Date of Birth	Age	Relationship	Have you ever been a patient at Sinai?	
				Yes ○	No ○
				Yes ○	No ○
				Yes ○	No ○
				Yes ○	No ○
				Yes ○	No ○
				Yes ○	No ○

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 ○

Return application to: Levindale Hebrew Geriatric Center and Hospital
2434 West Belvedere Ave
Patient Financial Services
Baltimore, MD 21215

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Patient Financial Services
For Hospital / Department / Agency use only
Originator Name: _____
Department: _____ **Ext** _____
Agency Name: _____

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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 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 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 _____
			Total: _____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car Payment(s)	_____
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 your monthly payment?_____

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, 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.

X_____ **X**_____

Applicants signature Date

X_____

Relationship to Patient