LIFEBRIDGE HEALTH

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 all sources 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 Dept.of Social Services **(If resident of Maryland)** _____
   F. Proof of Unemployment Compensation _____
   G. PIP exhausted benefit letter _____

2. Please provide copies of the following tax information:

   A. W-2 Forms _____
   B. Previous year's Tax Forms _____

3. **If resident of Maryland** please provide denial letter from the 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 your completed application and all applicable documents within 14 days of receipt. Your application will not be reviewed without providing 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 410 601-1094 or (800) 788-6995 Monday – Friday 7:30 am - 5:00 pm

Please return to -
**Patient Financial Services, Attention: Customer Service, 2401 West Belvedere Avenue, Baltimore, Maryland 21215**

Yours truly,

Patient Financial Services
Customer Service

*For Hospital / Department / Agency use only*

**Originator Name:** _____

**Department:** _____ **Ext.** _____

**Agency Name:** _____

LIFEBRIDGE HEALTH

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: Patient Financial Services
Attn: Customer Service
2401 W. Belvedere Avenue
Baltimore, MD 21215

Patient Financial Services

*For Hospital / Department / Agency use only*

Originator Name: _____

Department: _____ Ext _____

Agency Name: _____

## *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 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_____ Applicants signature

X_____ Date

X_____ Relationship to Patient