
St. Joseph Medical Center

Where the experts are.

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 all household members, recent pay stubs
- Bank statements showing interest
- Award letters from Social Security Administration or Department of Social Services
- Most recent years W-2 form
- Most recent years tax return
- 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: _____

 City State Zip code Country

Employer Name: _____
Work Address: _____

 City State Zip code Phone: _____

Household members:

_____	_____	_____
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 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	_____
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 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.

Applicant signature

Date

Relationship to Patient