

Suburban Hospital
Attention: Patient Accounting
8600 Old Georgetown Road
Bethesda, MD 20814



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 Country

Employer Name _____ Phone _____

Work Address _____

_____ City State Zip Code

Household members:

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

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 amounts	_____
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

PLEASE MAIL INFORMATION TO:
Suburban Hospital
Attention: Patient Accounting
8600 Old Georgetown Road
Bethesda, MD 20814



SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #: _____

1. What is the patient's age? _____
2. Is the patient a U.S. citizen or permanent resident? Yes or No
3. Is patient pregnant? Yes or No
4. Does patient have children under 21 years of age living at home? Yes or No
5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No
6. Is patient currently receiving SSI or SSDI benefits? Yes or No
7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

Family Size:

Individual: \$2,500.00

Two people: \$3,000.00

For each additional family member, add \$100.00

(Example: For a family of four, if you have total liquid assets of less than \$3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
9. Is patient homeless? Yes or No
10. Does patient participate in WIC? Yes or No
11. Does patient receive Food Stamps? Yes or No
12. Does patient currently have:
 Medical Assistance Pharmacy Only Yes or No
 QMB coverage/ SLMB coverage Yes or No
 PAC Coverage Yes or No
13. Is patient employed? Yes or No
 If no, date became unemployed. _____
 Eligible for COBRA health insurance coverage? Yes or No



SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____

MEDICAL RECORD #: _____

Date: _____

Family Income for twelve (12) calendar months preceding the date of this application: _____

Medical Debt incurred at Suburban Hospital (not including co-insurance, co-payments, or deductibles) for the twelve (12) calendar months preceding the date of this application:

Date of Service	Amount Owed
_____	_____
_____	_____
_____	_____
_____	_____

All documentation submitted becomes part of this application.

All the information submitted in the application is true and accurate to the best of my knowledge, information and belief.

Applicant's Signature

Date

Relationship to Patient

For Internal Use: Reviewed By: _____ Date: _____

Income: _____ 25% of income: _____

Medical Debt: _____ Percentage of Allowance: _____

Reduction: _____

Balance Due: _____

Monthly Payment Amount: _____ Length of Payment Plan: _____ months

PLEASE MAIL INFORMATION TO:

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Attention: Patient Accounting
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PATIENT BILLING and FINANCIAL ASSISTANCE INFORMATION
SHEET

Billing Rights and Obligations

Not all medical costs are covered by insurance. The hospital makes every effort to see that you are billed correctly. It is up to you to provide complete and accurate information about your health insurance coverage when you are brought in to the hospital or visit an outpatient clinic. This will help make sure that your insurance company is billed on time. Some insurance companies require that bills be sent in soon after you receive treatment or they may not pay the bill. Your final bill will reflect the actual cost of care minus any insurance payment received and/or payment made at the time of your visit. All charges not covered by your insurance are your responsibility.

Financial Assistance

If you are unable to pay for medical care, you **may qualify for Free or Reduced-Cost Medically Necessary Care** if you:

- Have no other insurance options
- Have been denied medical assistance or fail to meet all eligibility requirements
- Meet specific financial criteria

If you do not qualify for Medical Assistance or financial assistance, you may be eligible for an extended payment plan for your medical bill.

Call: 301-896-6088

With questions concerning:

- Your hospital bill
- Your rights and obligations with regard to your hospital bill
- Your rights and obligations with regard to reduced-cost medically necessary care due to financial hardship
- How to apply for free and reduced-cost care
- How to apply for Maryland Medical Assistance or other programs that may help pay your medical bills

For information about Maryland Medical Assistance

Contact your local department of Social Services

1-800-332-6347 TTY 1-800-925-4434

Or visit: www.dhr.state.md.us

Physician charges are not included in hospital bills and are billed separately.



Application for Financial Assistance

PLEASE RETURN ALL REQUESTED DOCUMENTATION TO:

Suburban Hospital, Inc.
Attention: Patient Accounting
8600 Old Georgetown Road
Bethesda, MD 20814

If you have questions, please call the Financial Assistance Coordinator
at 301-896-6088

Please complete this application if you are interested in applying for financial assistance with Suburban Hospital. The application should be returned to Suburban Hospital at the address above with all required substantiating documentation. It is your responsibility to complete this form in an accurate, honest, and complete manner. Failure to do so may result in denial of your application.

If you are eligible to apply for Medical Assistance (Medicaid) benefits, you shall be required to do so before Financial Assistance will be granted. For questions regarding Medical Assistance eligibility and the application process, please contact your **Local Department of Social Services (LDSS)**. **To find your LDSS, please call 1-800-332-6347.**

This application will be denied if not returned within 30 days of the date of service with complete substantiating documentation. This is a 2 page application; please complete both pages. In addition, all applications must be accompanied by a completed Patient Profile Questionnaire. The optional Medical Financial Hardship Application may also be submitted. Please note that the information you provide to the Financial Assistance Coordinator shall be held in the strictest confidence and only used to assist in the resolution of your outstanding medical bills.

Please attach the following required substantiating documentation.

Your application will be denied if all required documents are not supplied.

- a) Copies of your LAST TWO PAY STUBS
- b) Copy of your W-2 for the LAST TAX PERIOD
- c) Copies of your SPOUSE'S LAST TWO PAY STUBS
- d) Copy of your SPOUSE'S W-2 for the LAST TAX PERIOD
- e) Copy of your last INCOME TAX RETURN
- f) Please add a separate sheet of paper if there is any additional information you would like to be considered to help achieve a more complete understanding of your financial situation.

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