

Mailing Address:
501 6th Avenue South,
Attn: Department # 2405
St. Petersburg, FL 33701

Physical Address:
601 7th Street South, Suite #100
St. Petersburg, FL 33701

727-767-3475 P
achfinancialassist@jhmi.edu
www.hopkinsallchildrens.org



Financial Assistance Application Checklist

Applicant's Name: _____

The following documents are required for a completed application to be submitted and reviewed timely:

- Completed Financial Assistance Application
- Most recent tax return for each member of the household or (non-filing letter from IRS).
- Six (6) most recent pay stubs for each member of the household
- Other income verification such as:
 - Disability Income, Unemployment Letters, Worker's Compensation Letters, Alimony,
 - Retirement Income, Letter(s) from employer and/or other proof as applicable.
- Medicaid, Medicare, and/or Marketplace application status, if applicable
- Reasonable proof of declared expenses, if applicable
- All other unpaid medical bills, if applicable

If at any time in completing this application, the available lines or spacing does not provide enough space for your household's complete information, please provide your answers at the end with the available spaces and/or additional paper as necessary.

INTERNAL USE ONLY:

Application Received Date: _____

Application Review Date: _____

Final Determined Status: ___ Approved ___ Denied

MR#: _____

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Applicant Name: _____

All Working Household Members Place of Employment:

Household Member Name _____ Employment Company Name _____

Household Member Name _____ Employment Company Name _____

Have you applied for Medical Assistance? Yes No, please apply

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 | _____ |
| Veteran's Benefits | _____ |
| Alimony | _____ |
| Rental Property Income | _____ |
| Strike Benefits | _____ |
| Military Allotment | _____ |
| Farm or Self-Employment | _____ |
| Other Income Sources | _____ |

II. Liquid Assets:

| | Current Balance (\$) |
|-----------------------------------|----------------------|
| Checking Account | _____ |
| Savings Account | _____ |
| Stock, Bonds, CD, or Money Market | _____ |
| Other Accounts | _____ |

Scan to: View Images >> Financial Documents

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III. Other Assets:

If you own any of the following items, please list the type and approximate value:

| | | | |
|--------------------|-------|------|----------|
| Home Loan Balance | | \$ | _____ |
| Other Property | | \$ | _____ |
| | Make | Year | _____ |
| Automobile | _____ | | \$ _____ |
| Additional Vehicle | _____ | | \$ _____ |
| Additional Vehicle | _____ | | \$ _____ |
| Total: \$ | | | _____ |

IV. Monthly Expenses:

| | |
|------------------------|-------------|
| | Amount (\$) |
| Rent or Mortgage | _____ |
| Utilities | _____ |
| Car Payment(s) | _____ |
| Credit Card(s) | _____ |
| Car Insurance | _____ |
| Health Insurance | _____ |
| Other Medical Expenses | _____ |

V. Other Expenses:

Do you have any other unpaid medical bills? Yes No

If yes, for what services? _____

If you have a payment plan, what is the monthly amount? \$ _____

Johns Hopkins All Children's may request additional information in order to make a supplemental determination, based on your request for the hospital to extend financial assistance.

