Kennedy Krieger Institute
Financial Assistance Application
Application Information

Kennedy Krieger Institute provides financial assistance for medically necessary care to eligible individuals and families on a sliding scale based on financial need. Children and patients who reside in a foreign country are not eligible for Financial Assistance. This policy shall apply regardless of the patient's immigration status.

Eligibility Criteria:

MEDICAL INDIGENCY	CATASTROPHIC ASSISTANCE
❑ Patients who are beneficiaries/recipients of a social service program (WIC, SNAP, etc) OR ❑ Household income is less than 400% of the Federal Poverty Guideline	❑ Household income is more than 400% of the Federal Poverty Guideline ❑ Medical bills greater than 60% of income

Application Process:

1. Fill out the application in this packet.
    a. Include supporting documentation in packet checklist.
2. Mail or drop off your application and supporting documentation, including the checklist, to:

    Patient Accounting
    1741 Ashland Ave, 6th floor
    Baltimore, MD 21205
3. Your application will be reviewed and you will receive one of the following:
    a. If you meet eligibility criteria, you will receive a letter indicating the amount of your award.
    b. If you do not meet eligibility criteria, you will receive letter notification that you do not qualify for financial assistance.
    c. If your application is incomplete, you will receive a letter indicating what documentation or information would be needed for the application to be considered complete. The missing documentation must be submitted within 30 days of the letter.
4. You can contact us for assistance with the application process by calling 443-923-1870.

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Documentation Checklist

Application

- ❑ Application Packet

Medical Indigency Required Documentation

- ❑ Proof of enrollment in a social service program (WIC, SNAP, etc), if applicable
- ❑ Copies of all health insurance cards.

OR

- ❑ Copy of last year's federal tax return. If married and filed separately, include copies of both returns.
- ❑ Copy of your last 3 pay stubs, letter from employer, or proof of unemployment status.
- ❑ Copy of social security award letter, if applicable.
- ❑ Copies of all health insurance cards.

Catastrophic Assistance Required Documentation

- ❑ Copy of last year's tax return. If married and filed separately, include copies of both returns.
- ❑ Copy of your last 3 pay stubs, letter from employer, or proof of unemployment status.
- ❑ Copy of social security award letter (if applicable).
- ❑ Copies of all health insurance cards.
- ❑ Copies of non-Kennedy Krieger Institute health bills.

Family Size	Income Guideline for Medical Indigency				
1	$0 - $29,160	$29,161-$36,450	$36,451-$43,740	$43,741-$51,030	$51,031-$58,320
2	$0 - $39,440	$39,441-$49,300	$49,301-$59,160	$59,161-$69,020	$69,021-$78,880
3	$0 -$49,720	$49,721-$62,150	$62,151-$74,580	$74,581-$87,010	$87,011-$99,440
4	$0 - $60,000	$60,001-$75,000	$75,001-$90,000	$90,001-$105,000	$105,001-$120,000
5	$0 - $70,280	$70,281-$87,850	$87,851-$105,420	$105,421-$122,990	$122,991-$140,560
6	$0 - $80,560	$80,561-$100,700	$100,701-$120,840	$120,841-$140,980	$140,981-$161,120
7	$0 - $90,840	$90,841-$113,550	$113,551-$136,260	$136,261-$158,970	$158,971-$181,680
8	$0 - $101,120	$101,121-$126,400	$126,401-$151,680	$151,681-$176,960	$176,961-$202,240
Discount	100%	80%	60%	40%	20%

Updated December 2023

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Application Date	

Guarantor Information

Name		DOB	
Relationship to Patient		SSN	
Mailing Address			
Email Address		Phone Number	

Household Information

Annual Income		Monthly Income	
For Catastrophic Assistance only, indicate total outstanding medical bills			

Family Living in Household

Name	Relationship to Guarantor	DOB	Patient at KKI?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Additional Questions

Please respond so we may identify other sources of assistance.

Is the medical care needed due to an accident? If yes, indicate date and type of accident. _____	Yes No
Is the patient seeking medical care due to being a victim of a crime?	Yes No
Do you currently have health insurance? Please include copies of all insurance cards.	Yes No
Do you have a Health/Flexible/Consumer Spending or Savings account? If so, how much is available for the applicable year? _____	Yes No
Have you or your spouse ever served in the U.S. Military?	Yes No
Have you applied for Medicaid in the past 6 months?	Yes No
Are you, or will you be unable to work due to a physical or mental disability? If yes, for how many months? _____	Yes No
Have you applied for Social Security Disability? If yes, when: _____	Yes No
Are you receiving state or government assistance (e.g., food assistance)? If yes, indicate the monthly benefit amount. _____	Yes No

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