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**POLICY**

**This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: Howard County General Hospital (HCGH) and Suburban Hospital (SH).**

Purpose

JHHS is committed to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, and will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient’s individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient’s existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted so long as other requirements are met.


**FINANCIAL ASSISTANCE FOR PHYSICIANS PROVIDING CARE NOTICE:**

Attached as EXHIBIT D is a list of physicians that provide emergency and medically necessary care as defined in this policy at HCGH and SH. The lists indicates if the doctor is covered under this policy. If the doctor is not covered under this policy, patients should contact the physician’s office to determine if the physician offers financial assistance and if so what the physician’s financial assistance policy provides.

Definitions

**Medical Debt** Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the JHHS hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay(opting out of insurance coverage, or insurance billing )

**Liquid Assets** Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of \$150,000 in equity in patient’s primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid

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Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.


Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.
Medically Necessary Care	Medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for the purposes of this policy does not include elective or cosmetic procedures.
Family Income	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.
Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each marketplace in which it is sold.

## **PROCEDURES**


1. An evaluation for Financial Assistance can begin in a number of ways:

For example:

- A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
  - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
  - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.
2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.
  3. Designated staff may meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.


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- a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, as defined by Medicaid regulations. To help applicants complete the process, a statement of conditional approval will be provided that will list the paperwork required for a final determination of eligibility.
  - b. Applications received will be sent to the JHHS Patient Financial Services Department for review; a written determination of probable eligibility will be issued to the patient.
  - c. At HCGH, complete applications with all supporting documentation submitted at the hospital are approved via the appropriate signature authority process. Once approved and signed off on, the approved applications will be sent to the JHHS Patient Financial Services Department's to mail patient a written determination of eligibility.
4. To determine final eligibility, the following criteria must be met:
- a. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
  - b. All insurance benefits must have been exhausted.
5. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:
- a. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).
  - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
  - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
  - d. A Medical Assistance Notice of Determination (if applicable).
  - e. Proof of disability income (if applicable).
  - f. Reasonable proof of other declared expenses.
  - g. Non-U.S. citizens must complete the Financial Assistance Application (Exhibit A). In addition, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After

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obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO ( HCGH) or Director of PFS and/or CFO (SH) to determine if additional information is necessary.

- h. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...
6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles for medical costs billed by a JHHS hospital unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines. At HCGH, the Financial Counselor will forward to Director, Revenue Cycle for review and final eligibility based upon JHMI guidelines.
    - a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments for reconsideration to the CFO (HCGH) or Director PFS and CFO (SH) for final evaluation and decision.
    - b. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will have a final determination made no later than 30 days from the date the application was considered complete. The Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will base their determination of financial need on JHHS guidelines.
  7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
  8. Services provided to patients registered as Voluntary Self Pay do not qualify for Financial Assistance.
  9. A department operating programs under a grant or other outside governing authority (i.e.: Psychiatry Program) may continue to use a government-sponsored application process and associated income scale.
  10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient makes a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.
  11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts

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for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patients representative requests an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

12. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.
13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application (Exhibit A) unless they meet Presumptive Financial Assistance Eligibility criteria (see Appendix A-1). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
14. Patients who receive coverage on a Qualified Health Plan and ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medically necessary care shall be required to submit a Financial Assistance Application if the patient is at or below 200% of Federal Poverty Guidelines.
15. If a patient account has been assigned to a collection agency, and patient or guarantor requests financial assistance or appears to qualify for financial assistance, the collection agency shall notify PFS and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to PFS for review and determination and shall place the account on hold for 45 days pending further instruction from PFS.
16. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding \$25. If hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.
17. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.

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**REFERENCE<sup>1</sup>**

**JHHS Finance Policies and Procedures Manual**

Policy No. FIN017 - Signature Authority: Patient Financial Services

Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Code of Maryland Regulations COMAR 10.37.10.26, et seq

Maryland Code Health General 19-214, et seq

Federal Poverty Guidelines (Updated annually) in Federal Register

**RESPONSIBILITIES - HCGH, SH**

Financial Counselor (Pre-Admission/Admission/In-House/Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance

Understand current criteria for Assistance qualifications.

Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form.

On the day preliminary application is received, send to Patient Financial Services Department's for determination of probable eligibility.

Review preliminary application (Exhibit A), Patient Profile Questionnaire (Exhibit B) and Medical Financial Hardship Application (Exhibit C), if submitted, to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.

If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review.


Review and ensure completion of final application.

Deliver completed final application to appropriate management.

Document all transactions in all applicable patient accounts comments.

Identify retroactive candidates; initiate final application process.

<sup>1</sup> NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

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Management Personnel  
(Supervisor/Manager/Director)

Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies.

Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.]

Notices will not be sent to Presumptive Eligibility recipients.

Financial Management Personnel  
(Senior Director/Assistant Treasurer  
or affiliate equivalent)  
CP Director and Management Staff

Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

**SPONSOR**

CFO (HCGH, SH)  
Director of Revenue Cycle (HCGH)  
Director, PFS (SH)


**REVIEW CYCLE**

Two (2) years

**APPROVAL**

\_\_\_\_\_  
Sr. Vice President and Chief Financial Officer, JHM


\_\_\_\_\_  
Date

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**APPENDIX A  
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES**

1. Each patient requesting Financial Assistance must complete a JHM/Financial Assistance Application (also known as the Maryland State Uniform Financial Assistance Application) Exhibit A, and Patient Profile Questionnaire, Exhibit B. If patient wishes to be considered for Medical Financial Hardship, patient must submit Medical Financial Hardship Application, Exhibit C.
2. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.
3. The patient must apply for Medical Assistance and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
4. Proof of income must be provided with the final application. Acceptable proofs include:
  - (a) Prior-year tax return;
  - (b) Current pay stubs;
  - (c) Letter from employer, or if unemployed documentation verifying unemployed status; and
  - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
  - (e) For non-U.S. citizens, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.
5. Patients will be eligible for Financial Assistance if their maximum family (husband and wife, same sex married couples) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets in excess of \$10,000 which would be available to satisfy their JHHS affiliate bills.
6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify. If it is clear that a non-U.S. citizen will not be eligible for Medical Assistance, a Medical Assistance Notice of Determination will not be necessary.
7. Patients who chose to become voluntary self pay patients do not qualify for Financial Assistance for the amount owed on any account registered as Voluntary Self Pay.
8. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and private room accommodations that are not medically necessary. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is an "Elective Admission" or a "Medically Necessary Admission," the patient's admitting physician shall be consulted and the matter will also be directed to the physician advisor appointed by the hospital.



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9. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted. The Financial Counselor will issue the final eligibility determination.
10. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.
11. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application (Exhibit A) will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial Assistance from another affiliate.
12. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

Exceptions

The Vice President, Finance/CFO may make exceptions according to individual circumstances.


**FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID**

<b>TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES</b>						
<b>Effective 3/1/16</b>						
# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	\$ 23,760	\$ 26,136	\$ 28,512	\$ 30,888	\$ 33,264	\$ 35,640
2	\$ 32,040	\$ 35,244	\$ 38,448	\$ 41,652	\$ 44,856	\$ 48,060
3	\$ 40,320	\$ 44,352	\$ 48,384	\$ 52,416	\$ 56,448	\$ 60,480
4	\$ 48,600	\$ 53,460	\$ 58,320	\$ 63,180	\$ 68,040	\$ 72,900
5	\$ 56,880	\$ 62,568	\$ 68,256	\$ 73,944	\$ 79,632	\$ 85,320
6	\$ 65,160	\$ 71,676	\$ 78,192	\$ 84,708	\$ 91,224	\$ 97,740
7	\$ 73,460	\$ 80,806	\$ 88,152	\$ 95,498	\$ 102,844	\$ 110,190
8*	\$ 81,780	\$ 89,958	\$ 98,136	\$ 106,314	\$ 114,492	\$ 122,670
**amt for each mbr	\$8,320	\$9,152	\$9,984	\$10,816	\$11,648	\$12,480
Allowance to Give:	100%	80%	60%	40%	30%	20%


\*200% of Poverty Guidelines

\*\* For family units with more than eight (8) members.

EXAMPLE: Annual Family Income \$55,000  
# of Persons in Family 4  
Applicable Poverty Income Level \$48,600  
Upper Limits of Income for Allowance Range \$58,320 (60% range)

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(\$55,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

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## Appendix A-1


### Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- active enrollees of the Chase Brexton Health Center (See Appendix C) (applicable for HCGH patients)
- Participation in Women, Infants and Children Programs (WIC)\*
- Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility \*
- Households with children in the free or reduced lunch program\*
- Low-income household energy assistance program participation\*
- Eligibility for other state or local assistance programs which have financial eligibility at or below 200% of FPL
- patients referred to Suburban Hospital by organizations which have partnered with Suburban (See Appendix E)
- Patient is deceased with no known estate
- Health Department moms – For non-emergent outpatient visits not covered by medical assistance
- Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
- Patients returned by SRT as not meeting disability criteria but who meet the financial requirements for Medical Assistance

\*These life circumstances are set forth in COMAR 10.37.10.26 A-2. The patient needs to submit proof of enrollment in these programs within 30 days of treatment unless the patient requests an additional 30 days.



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**APPENDIX B  
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES**

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance. This determination will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom:

- 1.) Medical Debt incurred over a twelve (12) month period exceeds 25% of the Family Income creating Medical Financial Hardship; and
- 2.) who meet the income standards for this level of Assistance are met.

For those patients who are eligible for reduced cost care under the Financial Assistance criteria and also qualify under the Medical Financial Hardship Assistance Guidelines, JHHS shall apply the reduction in charges that is most favorable to the patient.

Medical Financial Hardship is defined as Medical Debt for Medically Necessary treatment incurred by a family over a twelve (12) month period that exceeds 25% of that family's income.


Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Care billed by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, unless the patient is below 200% of Federal Poverty Guidelines.

The patient/guarantor can request that such a determination be made by submitting a Medical Financial Hardship Assistance Application (Exhibit C), when submitting JHM/Financial Assistance Application, also known as the Maryland State Uniform Financial Assistance Application (Exhibit A), and the Patient Profile Questionnaire (Exhibit B). The patient guarantor must also submit financial documentation of family income for the twelve (12) calendar months preceding the application date and documentation evidencing Medical Debt of at least 25% of family income.

Once a patient is approved for Medical Hardship Financial Assistance, Medical Hardship Financial Assistance coverage shall be effective starting the month of the first qualifying service and the following twelve (12) calendar months. It shall cover those members of the patient's Immediate Family residing in the same household. The patient and the Immediate Family members shall remain eligible for reduced cost Medically Necessary Care when seeking subsequent care at the same hospital for twelve (12) calendar months beginning on the date on which the reduced cost Medically Necessary Care was initially received. Coverage shall not apply to Elective Admissions or Elective or cosmetic procedures. However, the patient or the patient's immediate family member residing in the same household must notify the hospital of their eligibility for the reduced cost Medically Necessary Care at registration or admission.

General Conditions for Medical Financial Hardship Assistance Application:

1. Patient's income is under 500% of the Federal Poverty Level.
2. Patient has exhausted all insurance coverage.
3. Patient account balances for patients who chose to register as voluntary self pay shall not counted toward Medical Debt for Medical Financial Hardship Assistance.
4. Patient/guarantor do not own Liquid Assets in excess of \$10,000 which would be available to satisfy their JHHS affiliate bills.

 <p><b>JOHNS HOPKINS</b> M E D I C I N E JOHNS HOPKINS HEALTH SYSTEM</p>	<p><b>The Johns Hopkins Health System Policy &amp; Procedure</b></p>	<p><i>Policy Number</i></p>	<p>FIN034H</p>
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5. Patient is not eligible for any of the following:
  - Medical Assistance
  - Other forms of assistance available through JHM affiliates
6. Patient is not eligible for The JHM Financial Assistance Program or is eligible but the Medical Financial Hardship Program may be more favorable to the patient.
7. The affiliate has the right to request patient to file updated supporting documentation.
8. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.
9. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the Medical Financial Hardship Assistance program, the patient is still required to file a JHHS Medical Financial Hardship Assistance Application but not to submit duplicate supporting documentation.

#### Factors for Consideration

The following factors will be considered in evaluating a Medical Financial Hardship Assistance Application:


- Medical Debt incurred over the twelve (12) months preceding the date of the Financial Hardship Assistance Application at the JHHS treating facility where the application was made.
- Liquid Assets (leaving a residual of \$10,000)
- Family Income for the twelve (12) calendar months preceding the date of the Financial Hardship Assistance Application
- Supporting Documentation

#### Exceptions

The Vice President, Finance/CFO or designee may make exceptions according to individual circumstances.

#### Evaluation Method and Process

1. The Financial Counselor will review the Medical Financial Hardship Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Medical Financial Hardship Assistance Worksheet (found on the bottom of the application) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

 <p><b>JOHNS HOPKINS</b> M E D I C I N E JOHNS HOPKINS H E A L T H S Y S T E M</p>	<b>The Johns Hopkins Health System Policy &amp; Procedure</b>		<i>Policy Number</i> FIN034H
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**MEDICAL HARDSHIP FINANCIAL GRID**


Upper Limits of Family Income for Allowance Range

# of Persons in Family	*300% of FPL	400% of FPL	500% of FPL
1	\$ 35,640	\$ 47,520	\$ 59,400
2	\$ 48,060	\$ 64,080	\$ 80,100
3	\$ 60,480	\$ 80,640	\$ 100,800
4	\$ 72,900	\$ 97,200	\$ 121,500
5	\$ 85,320	\$ 113,760	\$ 142,200
6	\$ 97,740	\$ 130,320	\$ 162,900
7	\$ 110,190	\$ 146,920	\$ 183,650
8*	\$ 122,670	\$ 163,560	\$ 204,450
Allowance to Give:	50%	35%	20%

For family units with more than 8 members, add \$12,480 for each additional person at 300% of FPL, \$16,640 at 400% at FPL; and \$20,800 at 500% of FPL.





 <p><b>JOHNS HOPKINS</b> MEDICINE JOHNS HOPKINS HEALTH SYSTEM</p>	<p><b>The Johns Hopkins Health System Policy &amp; Procedure</b></p>	<p><i>Policy Number</i></p>	<p>FIN034H</p>
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**APPENDIX C (HCGH only)  
FINANCIAL ASSISTANCE FOR CHASE BREXTON PATIENTS**

Purpose

Chase Brexton Health Services, Inc. is a non-profit, community based organization that provides a wide range of medical, psychological and social services on a non-discriminatory basis in Baltimore City, Baltimore County, and Howard County. Chase Brexton offers services to everyone regardless of their ability to pay. Chase Brexton cares for those who are uninsured or under-insured, those with Medicare and Medicaid, and those with commercial insurance. Chase Brexton has Case Managers that work with patients to determine eligibility for care at a low minimum fee, and/or appropriate programs and entitlements available to people with limited resources.


This procedure is for Howard County General Hospital registration sites, verification and scheduling and for Patient Financial Services. It outlines the treatment of patients that have qualified for Chase Brexton Health Services. It is the policy of HCGH to accept patients previously screened by Chase Brexton for financial assistance. Patients will not have to apply for assistance but will need to notify HCGH of their participation in this program.

Inpatient/Outpatient cases

All Chase Brexton inpatients are screened by the Howard County General Hospital's Financial Counselor for possible medical assistance. Appointments are made with Howard County General Hospital's in-house medical assistance Case Worker or MA extender for the application process. If medical assistance is received, the claim is billed to Medical Assistance for payment. If the patient is not eligible for medical assistance, the insurance plan of (2200032) Chase Brexton is assigned to the account. The Financial Counselor will also complete the FPL table based on income information provided by Chase Brexton and the billing indicator upon completion. The claim will be automatically written off to the financial assistance/charity care allowance code when the final bill is released.

**PROCEDURE**

1. When a patient presents for services at HCGH and states they are associated with the Chase Brexton health center, the registration staff will enter the insurance code of (2200032) Chase Brexton into EPIC if it's not already there. If the Chase Brexton coverage is already in EPIC, the registration staff will select that coverage for the account.
2. The Sr. Financial Counselor has a workqueue in EPIC that contains all patients registered with Chase Brexton.
3. The Sr. Financial Counselor will review all patients in the workqueue daily to validate they are active with the Chase Brexton health center and what level of charity care they qualify for based on their financial information.
4. The Sr. Financial Counselor is responsible for updating the FPL table to reflect the proper level of charity care and collecting the patient balance (if any).
5. The Sr. Financial Counselor is responsible for entering a from and through date into the FPL table that the patient is eligible to receive this level of charity care.
6. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Trainer of Patient Access for corrective action. These accounts will be changed to self pay and or other insurance as appropriate.

 <p><b>JOHNS HOPKINS</b> M E D I C I N E JOHNS HOPKINS HEALTH SYSTEM</p>	<b>The Johns Hopkins Health System Policy &amp; Procedure</b>		<i>Policy Number</i>	FIN034H
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**APPENDIX D (Suburban Hospital only)  
FINANCIAL ASSISTANCE FOR MONTGOMERY COUNTY AND LOCALLY BASED PROGRAMS FOR  
LOW INCOME UNINSURED PATIENTS**

Purpose

Suburban Hospital is partnered with several Montgomery County, MD and locally based programs that offer primary care services and/or connection to local specialty and hospital based care. Based on agreements with these partnered programs, Suburban Hospital provides access to inpatient and outpatient care to patients who would not otherwise be able to access or afford medically necessary care.

Policy

Suburban Hospital shall accept charity referrals for medical necessary care from the following providers: Catholic Charities, Mobile Med, Inc., Montgomery County Cancer Crusade, Primary Care Coalition, Project Access, and Proyecto Salud. Care is provided to such patients based on meeting eligibility requirements for one of the aforementioned local programs.

Patients must provide a program generated referral for care as proof of their enrollment in one of the above programs to qualify for presumptive approval for 100% free care. Suburban Hospital shall base acceptance of such referrals on the referring programs' enrollment of patients using their income based eligibility requirements which for these designated programs is at or below a maximum of 250% of the federal poverty guidelines.

Procedure

1. When a patient is scheduled and/or presents for services at SH, the patient must provide a referral form from one of the above programs as proof of enrollment.
2. Once the referral form is received, the Scheduler or Registrar will apply to the account a designated insurance mnemonic for the referring partnered program.
3. If no referral form is received by the patient, the account will be registered as self pay. The patient has 30 days to produce a referral or proof of enrollment in one of the partnered programs. An additional 30 days will be allowed upon request from the patient.
4. A Financial Counselor and/or Registrar will check the real time eligibility or Maryland EVS System to verify enrollment in Maryland Medicaid. If enrolled, Medicaid will prevail and free care presumptive approval will not apply.
5. Each hospital account with a designated insurance mnemonic for one of the partnered programs will be subject to final review for the existence of a program referral prior to application of the program driven charity adjustment. Presumptive approval for 100% free care applies to a single episode of care (account) only.

Exhibit A

Howard County General Hospital  
3910 Keswick Road, Suite S-5100  
Baltimore, MD 21211



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

## Exhibit A

### *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	_____
<b>Total</b>	_____

### *II. Liquid Assets*

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
<b>Total</b>	_____

### *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 _____
<b>Total</b>		_____

### *IV. Monthly Expenses*

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
<b>Total</b>	_____

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

Exhibit B

**PATIENT FINANCIAL SERVICES**  
**PATIENT PROFILE QUESTIONNAIRE**

HOSPITAL NAME: \_\_\_\_\_

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  
If not a Maryland resident, in what state does patient reside? \_\_\_\_\_
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

Exhibit C

**MEDICAL FINANCIAL HARDSHIP APPLICATION**

HOSPITAL NAME: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_  
(Include Zip Code)

MEDICAL RECORD #: \_\_\_\_\_

Date: \_\_\_\_\_

Family Income for twelve (12) calendar months preceding date of this application: \_\_\_\_\_

Medical Debt incurred at The Johns Hopkins 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: \_\_\_\_\_

**Exhibit B**

Monthly Payment Amount: \_\_\_\_\_

Plan: \_\_\_\_\_ month

Length of Payment