TITLE: FINANCIAL ASSISTANCE PLAN

PURPOSE:

The purpose of this policy is to document the Fort Washington Medical Center (FWMC) process for granting financial assistance where patients are unable to meet their obligations to the organization due to lack of insurance or other financial resources or other conditions of financial hardship.

POLICY:

Fort Washington Medical Center provides care to all patients regardless of ability to pay.

It is the policy of Fort Washington Medical Center to provide Financial Assistance based on inability to pay or high medical expenses for patients who meet specified financial criteria and request such assistance.

The determination of probable eligibility for Financial Assistance (or charity care services) will be made within two business days following a patient's request for such services, application for medical assistance or both.

FWMC will communicate the availability of financial assistance on the hospital website and in hospital publications.

A notice of FWMC's Financial Assistance Plan will be posted in the Admitting & Registration (Admissions) Department, Patient Accounts (Business Office), in the Emergency Department, and Administration.

Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

PROCEDURE:

1. Patient's will be informed of the following upon admission through the Financial Assistance Brochure/Information Sheet:
    a. Description of the Financial Assistance Policy;
    b. Patient's rights and obligations with regard to hospital billing and collection under the law;
    c. Contact information at the hospital that is available to assist the patient, the patient's family/significant other, or the patient's authorized representative in order to understand:
        i. The patient's hospital bill;
        ii. The patient's rights and obligations with regard to the hospital bill;
        iii. How to apply for free and reduced cost care in the billing office;
        iv. How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill.

d. Contact information for the Maryland Medical Assistance Program;

e. Physician charges are not included in the hospital bill and are billed separately.

2. The patient's initial bill will include reference on whom to contact for Financial Assistance Information.

3. The Financial Assistance Brochure/Information sheet will be distributed to each patient.

4. An evaluation for Financial Assistance can be commenced in a number of ways:
   a. A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
   b. 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.
   c. A physician or other clinician refers a patient for financial assistance evaluation for potential admission.

5. The Insurance Verification Representative/Financial Counselor (located in the Admitting office), Admitting and Patient Accounts personnel will be responsible for taking Financial Assistance applications.

6. When a patient requests Financial Assistance, the staff member who receives the request will:

   a. AFTERHOURS/WEEKEND: Give the patient a Financial Assistance Program and Practices brochure and application (attached) and refer the patient to contact the Insurance Verification Representative/Financial Counselor. Patients may drop off applications with anyone in the Admitting area.

   b. DURING THE WORKWEEK NORMAL BUSINESS HOURS: Refer the patient to the Insurance Verification Representative/Financial Counselor.

7. To make a determination of **probable eligibility** for Financial Assistance, the applicant must complete the Maryland State Uniform Application for Financial Assistance.

   a. The Insurance Verification Representative/Financial Counselor will perform an assessment to determine if the patient meets preliminary criteria based on the family size/income as defined by Medicaid regulations (See Attached Poverty Level Guidelines Table).

   b. A Letter of Conditional Approval for probable eligibility (see attached) will be sent to the patient within two business days.

   c. The person seeking financial assistance may contact Insurance Verification at the end of the second business day to learn of the determination.

   d. Applications received and preliminary determinations made by the Insurance Verification Representative/Financial Counselor will be sent daily to Patient Accounts for review

8. In order to make the final determination for Financial Assistance as provided for in the letter of conditional approval, following documents must be provided to any personnel in Admitting or Patient Accounts.
   a. A copy of the conditional approval letter (attached).
   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.

9. The following must be met in order for a review for a final determination for a Financial Assistance adjustment:
   a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. In cases where the patient has active Medicare Prescription Drug Program or Qualified Medicare Beneficiary (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. Review viability of offering a payment plan agreement.
   c. All insurance benefits have been exhausted.

10. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. If the patient's application for Financial Assistance is determined to be complete and appropriate:
    a. the Insurance Verification Representative/Financial Counselor will forward all documents and recommended patient's level of eligibility to the Director, Patient Accounts;
    b. the Director of Patient Accounts has the authority to approve/reject charity amounts less than $5,000; and
    c. The Chief Financial Officer has the authority to approve/reject charity amounts estimated to exceed $5,000.

13. A Letter of Final Determination (see attached) will be sent to the patient within 30 days to inform him/her eligibility for:
    a. Financial Assistance (Full or partial)
    b. Payment Plan
14. FWMC has the option to designate certain elective procedures for which no Financial Assistance options will be given.

15. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to Fort Washington Medical Center. If a patient is approved for a percentage allowance due to financial hardship and the patient does not make the required initial payment within 60 days towards their part of the bill, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.
16. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the Chief Financial Officer.
17. The Director of Patient Accounts will advise ineligible patients of other alternatives available to them including Medical Assistance or bank loans.
18. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date) and any projected medical expenses.
19. A determination of Financial Assistance will be re-evaluated every six (6) months as necessary.

GLOSSARY

TERM	DEFINITION
Catastrophic circumstances	A situation in which the self-pay portion of the FWMC medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 24 months or less.
Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.
Living Expenses	Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Permanent Resident	Holder of a United States Permanent Resident Card, also known as a "green card," which is an identification process card attesting the permanent resident status of alien in the United States of America. The green card serves as proof that its holder, a Lawful Permanent Resident (LPR), has been officially granted immigration benefits, which include permission to conditionally reside and take employment in the USA. The holder must maintain his permanent resident status, and can be removed if certain conditions of such status are not met.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)
Qualified Medicare Beneficiary (QMB)	The QMB program is for persons with limited resources whose incomes are at or below the national poverty level. It covers the cost of the Medicare premiums, coinsurance and deductibles that Medicare beneficiaries normally pay out of their own pockets.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
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.
Take Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.

TRAINING:

All staff will be informed of the Financial Assistance Plan and their specific responsibilities related to this plan.

Training will be provided at orientation, annual professional update and periodically as indicated.

DOCUMENTATION:

Registrars will document that they provided the newly admitted patient with the Financial Assistance Brochure/Information Sheet in the information system by placing a check in the HIPAA box. This check indicates that HIPAA, Patient's Rights Brochure and the Financial Assistance Brochure was given to the patient.

ANNUAL EVALUATION:

FWMC Trends of Annual Percent of Financial Benefit
Update Poverty Table
Review of literature for national, state and local legislative review to maintain current compliance.

APPROVAL PROCESS/COMMITTEE FLOW:

Finance Committee
Patient Safety/Performance Improvement Committee (for information)
President and CEO

REFERENCE (S):

Federal Register (Poverty Level Guidelines)
Maryland legislation §19-214.1
Maryland State Uniform Financial Assistance Application located at www.hscrc.**state**.**md**.us/consumers_**uniform**.cfm
FWMC Patient Rights and Responsibilities brochure
HB 1069 HSCRC Financial Assistance and Debt Collection Policy (Effective 6/1/2009)

ATTACHMENT(S):

Financial Assistance Program and Practices brochure
Letter of Conditional Approval
Letter of Determination
Financial Assistance Notice for lobby
2012 Poverty Level Guidelines (January 2012 Federal Register)
Maryland State Uniform Financial Assistance Application

DATE REVIEWED:	**SIGNATURE:**	**DATE REVIEWED:**	**SIGNATURE:**

APPROVED: **Verna S. Meacham, President/CEO**	**DATE ISSUED: 11/1998**	**DATE REVISED: 12/21/07, 6/2009, 4/2012 ,3/2013, 11/2014**

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

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

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

Maryland State Uniform Financial Assistance Application

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 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

Please return this form to a Financial Counselor located in the Admitting Office.
If you have any questions, please call: 301-203-2271 or 2154.

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

Maryland State Uniform Financial Assistance Application

Please return this form to a Financial Counselor located in the Admitting Office.
If you have any questions, please call: 301-203-2271 or 2154.

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

FINAL LETTER OF DETERMINATION FOR FINANCIAL ASSISTANCE

Date:

Dear Sir or Madam:

We have reviewed your MARYLAND STATE UNIFORM FINANCIAL APPLICATION. Based on the information provided, our final decision is that you qualify for:

- ☐ Financial Assistance
  - ☐ Full
  - ☐ Partial
- ☐ Payment Plan
- ☐ No Financial Assistance

We thank you for your patience during this review process. If we can be of further assistance, please feel free to call the Insurance Verification Representative/Financial Counselor at 301-203-2271 or 2154 or myself at 301-203-5401.

Sincerely,

Betty Edwards
Director, Patient Accounts

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

LETTER OF CONDITIONAL APPROVAL FOR FINANCIAL ASSISTANCE

Date:

Dear Sir or Madam:

We have reviewed your MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION. Based on the information provided, our preliminary decision is that you qualify for:

- ☐ Financial Assistance
  - ☐ Full
  - ☐ Partial
- ☐ Payment Plan
- ☐ No Financial Assistance

In order to make a final determination, please provide us with the following information:

- ☐ 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).
- ☐ 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.
- ☐ A Medical Assistance Notice of Determination (if applicable).
- ☐ Proof of US citizenship or permanent residence status.
- ☐ Proof of disability income (if applicable).
- ☐ Reasonable proof of other declared expenses.
- ☐ No other information is necessary at this time.
- ☐

You will be notified within thirty days of our final determination. We thank you for your patience. If you have any questions or if we can be of further assistance, please feel free to call the Insurance Verification Representative/Financial Counselor at 301-203-2271 or 2154 or myself at 301-203-5401.

Sincerely,

Betty Edwards
Director, Patient Accounts

2019 POVERTY GUILDLINE-ANNUAL

Persons in Hou	48 Contiguous States and D.C. Poverty Guidelines (Annual)									
	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%
1	$24,280	$30,350	$34,670	$38,990	$43,310	$47,630	$51,950	$56,270	$60,590	$64,910
2	$32,920	$37,240	$41,560	$45,880	$50,200	$54,520	$58,840	$63,160	$67,480	$71,800
3	$41,560	$45,880	$50,200	$54,520	$58,840	$63,160	$67,480	$71,800	$76,120	$80,440
4	$50,200	$54,520	$58,840	$63,160	$67,480	$71,800	$76,120	$80,440	$84,760	$89,080
5	$58,840	$63,160	$67,480	$71,800	$76,120	$80,440	$84,760	$89,080	$93,400	$97,720
6	$67,480	$71,800	$76,120	$80,440	$84,760	$89,080	$93,400	$97,720	$102,040	$106,360
7	$76,120	$80,440	$84,760	$89,080	$93,400	$97,720	$102,040	$106,360	$110,680	$115,000
8	$84,760	$89,080	$93,400	$97,720	$102,040	$106,360	$110,680	$115,000	$119,320	$123,640
Add 8,640 annually for family units with more than eight.										

2014 Dual Eligible Standards

	Qualifed Medicare Beneficiary (QMB)		Specified Low-Income Medicare Beneficiary (SLMB)		Qualifying Individuals (QI)		Qualified Disabled Working Individuals (QDWI)	
	Single	Couple	Single	Couple	Single	Couple	Single	Couple
Income:								
All *(Except AK & HI)*	993	1,331	1,187	1,593	1,333	1,790	3,975	5,329
Alaska	1,235	1,659	1,478	1,986	1,661	2,232	4,945	6,639
Hawaii	1,139	1,528	1,362	1,829	1,530	2,056	4,559	6,115
Resources:	$7,160	$10,750	$7,160	$10,750	$7,160	$10,750	$4,000	$6,000

IMPORTANT FINANCIAL INFORMATION

Visit the Insurance Verification Representative/ Financial Counselor located in the Admitting Office or call 301-203-2271 or 2154, if you need assistance with:

- Understanding your hospital bill;
- Your rights and obligations with regard to your hospital bill;
- How to apply for free and reduced cost care;
- How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill.

If it is after hours, a holiday or a weekend, you can pick up/drop off an application at FWMC's Registration or Information desk. If you need additional assistance, please call and leave a message with a Financial Counselor and someone will return your call within two business days.

Maryland Medical Assistance Program (HealthChoice):
1-800-977-7388 (TDD 1-800-977-7389)

All determinations of eligibility are solely at the discretion of FWMC.

This information is to be provided to the patient, the patient's family/significant other, or the patient's authorized representative before discharge or upon request.

BILLING INSTRUCTIONS on how to obtain financial information is communicated on the first hospital bill. Physician charges are not included in the hospital bill and are billed separately.

EXCLUSION: FWMC has the option to designate certain elective procedures for which no financial assistance option will be given.

TERMS OF AGREEMENT FOR FINANCIAL ASSISTANCE: Financial Assistance will remain valid for three months based on the initial date of the final determination letter. For recurring patients, patients may qualify for Financial Assistance for up to six months on the basis of a single application.

FWMC
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A Nexus Health Company

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11711 Livingston Road
Fort Washington, MD 20744
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Financial Assistance
PROGRAM & PRACTICES

at Fort Washington Medical Center

FINANCIAL ASSISTANCE PLAN

Fort Washington Medical Center (FWMC) follows a specific and compassionate policy for payment practices for financial assistance and uninsured billing. As a not-for-profit organization, one of the ways FWMC demonstrates its commitment to the community is through providing financial assistance to those in need. Our practices are an outgrowth of our mission and values.

FWMC'S RESPONSIBILITIES:

- FWMC will serve all patients regardless of their ability to pay.
- Be respectful of the individual's personal dignity and his/her ability to pay.
- Treat all patients equitably, whether insured, underinsured or uninsured.
- Consider the financial resources of patients and their families when establishing a maximum annual patient responsibility.
- Be diligent in our efforts to keep patients notified of their payment options and the opportunities for assistance.
- Ensure that our policies are consistent with the guidelines that have been issued by the American Hospital Association, federal, state and local legislative bodies, and other organizations.
- Provide financial assistance to those in need.

PATIENT'S RESPONSIBILITIES:

- Follow through with the application process.
- Provide all required documents necessary in order to be granted financial assistance.

FWMC PROCEDURE SUMMARY:

1. **An evaluation for financial assistance will be conducted when a:**
   - Patient with a self-pay balance due notifies Patient Accounts that he/she cannot afford to pay the bill and requests assistance.
   - Patient presents at registration or a clinical area without insurance and states that he/she cannot afford to pay the medical expenses.
   - Physician or other clinician refers a patient for a financial assistance evaluation.

2. **A Financial Counselor/Insurance Verification Representative will meet with the patient, upon request, to provide instructions on the Financial Assistance Application.** If it is after hours, a holiday or a weekend, the patient will be issued a copy of the Financial Assistance Program brochure and referred to call 301-203-2271 or 2154 and someone will contact them within two business days.

3. **To make a determination of probable eligibility for Financial Assistance, the applicant must complete the Maryland State Uniform Application for Financial Assistance.**
   - The Insurance Verification Representative/Financial Counselor will perform an assessment to determine if the patient meets preliminary criteria based on the family size/income as defined by Medicaid regulations.
   - A Letter of Conditional Approval for probable eligibility will be sent to the patient within two business days. The person seeking assistance may also call Insurance Verification at the end of the second business day to learn of the determination.
   - Applications received and preliminary determinations made by the Insurance Verification Representative/Financial Counselor will be sent daily to Patient Accounts for review.

4. **During the final determination of eligibility, the patient must provide a copy of the following to the Financial Counselor:**
   - Most recent Federal Income Tax Return.
   - Three most recent pay stubs (if employed).
   - Medical Assistance Notice of Determination (if applicable).
   - Proof of disability income (if applicable).
   - Reasonable proof of other declared expenses.

5. **The following are also necessary for a final determination:**
   - The patient must apply for Medical Assistance unless the Financial Counselor can readily determine that the patient would fail to meet the disability requirement.
   - Review possibility of a reasonable payment plan agreement.
   - All insurance benefits have been exhausted.

6. **The completed Maryland State Uniform Financial Assistance Application and required forms will be forwarded from the Financial Counselor to the Director of Patient Accounts for approval.**

7. **A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses.**

8. **Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to FWMC.** If a patient does not make the required payment within 60 days, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.

FORT WASHINGTON MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM

NOTICE TO PATIENTS

This hospital serves all patients regardless of ability to pay.

Financial assistance for essential services are offered depending on family size and income.

Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital will make a determination of probable eligibility.

You may apply for financial assistance at the front desk.

AVISO PARA LOS PACIENTES (Spanish)

Este hospital sirve a todos los pacientes independientemente de la capacidad de pago. Asistencia financiera para los servicios esenciales se ofrecen dependiendo del ingreso y tamaño de la familia.

Dentro de dos días hábiles tras la petición de un paciente para servicios de cuidado de caridad, solicitud de asistencia médica o ambos, el hospital hará una determinación de elegibilidad probable.

Usted puede solicitar asistencia financiera en la recepción.

PAALA SA PASYENTE (Tagalog)

Ang ospital na ito ay nagsisilbi sa lahat. Kahit walang kakayahang magbayad. Nagbibigay rin ang ospital ng bawas sa halaga ng serbisyo.

Depende sa laki ng pamilya at suweldo. Magpunta lang po sa front desk

para makakuha ng impormasyon.