Financial Assistance

POLICY STATEMENT

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

All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/ urgent services, applications for financial assistance will be completed and evaluated retrospectively and will not delay a patient from receiving care.

GBMC patients, depending on their financial condition and subject to the criteria in this policy, may be eligible to receive medical assistance (Medicaid), financial assistance or extended payment plans. To be consistent in the provision of financial assistance with all members of the community, GBMC applies definitive criteria, outlined herein, when making its financial assistance determination.

This policy covers all hospital facility services and services provided by GBMC physician practices/practice groups delivering emergent or medically necessary care. This policy does not cover emergent or medically necessary care provided by non-employed providers with privileges at GBMC (see **Exhibit A** for a listing of GBMC Physician Practices and Practice Groups covered under this policy).

An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance.

GBMC will give notice of its Financial Assistance Policy by providing access on its website and patient portal; providing notice of the policy in a newspaper with circulation in GBMC's service area on an annual basis; providing hard copies upon request and by mail free of charge; by providing notice and information about the policy on its billing statements, as part of the pre-admission, registration and discharge process; and, by displaying information about the policy at the Billing Office and all hospital registration points, which includes the Emergency Department. Upon request, GBMC will translate the policy into all primary languages of all significant patient populations in the community with limited English proficiency.

DEFINITIONS

A. Eligible Services: Services considered medically necessary may be eligible for financial assistance. Services considered elective are not eligible for financial assistance. Services for patients who incur additional out-of-pocket expenses by going out of their health insurance network, as specified by their insurance carrier, are not eligible for consideration.

B. Liquid Assets: Cash, securities, promissory notes, stocks, bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property easily convertible to cash. A safe harbor of $150,000 in equity in a patient's primary residence shall not be considered an asset convertible to cash. Equity in other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the IRS has granted preferential tax treatment.

PROCEDURES FOR STANDARD WORK

A. **APPLICATION REQUIREMENTS**

1. Self-pay patients who are scheduled for non-emergency surgery must complete a financial assistance application prior to the scheduled procedure or be required to pay a deposit prior to the surgery.
2. Patients meeting eligibility criteria for medical assistance (Medicaid) must apply and be determined ineligible prior to GBMC's final financial assistance determination.
3. GBMC requires patients to submit a Maryland Uniform Financial Assistance Application (**Exhibit B**) and any of the applicable documentation listed on the financial assistance application letter (**Exhibit C**) or otherwise requested by GBMC that applies to the patient and other adult members of the household, including but not limited to:
    a. Two (2) most recent paystubs for patient and any other person whose income is considered part of the family income, as defined by Medicaid regulations;
    b. A copy of patient's Federal Income Tax Return (if married and filing separately, then 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 patient's or household member's Social Security award letter, if applicable;
    d. A copy of patient's Medical Assistance determination letter, if applicable;
    e. Proof of disability income, if applicable;
    f. If unemployed, proof of unemployment (e.g. Statement from the Office of Unemployment Insurance);
    g. Proof of citizenship and Maryland residence;
    h. Relevant statements regarding Liquid Assets.

B. **REVIEW PROCESS**

1. To qualify for financial assistance, in any form, a patient must supply all requested documentation and proof to the requesting GBMC Collection Manager or Financial Assistance Coordinator. Failure

to supply requested information or documentation within fifteen (15) days of the date of a request from GBMC may result in a patient's ineligibility for financial assistance.

2. Following a patient's request for financial assistance, application for medical assistance, or both, GBMC will render and communicate to the patient a probable eligibility determination within two (2) business days.

    a. Probable Eligibility: GBMC will provide the patient a probable eligibility determination within two (2) business days of request. To provide a probable eligibility determination, GBMC will utilize the patient's completed and submitted Maryland Uniform Financial Assistance Application **(Exhibit B).** Please note that supporting documentation with the application will assist in the probable determination, but is not required. However, supporting documentation will be required for the final determination

    b. Final eligibility determination will be based on all criteria and requirements set forth in this policy.

3. Each patient must agree to a credit bureau report as a condition of consideration for financial assistance.

4. If a patient is approved for financial assistance or a payment plan, he/she will receive a financial assistance award letter. If a patient is denied financial assistance, he/she will receive a denial letter to the address listed in the financial assistance application.

5. Patients have the right to request an appeal of any denial by responding to the denial letter within fifteen (15) days of the date of the denial letter. Appeals will be reviewed by the Executive Director of Revenue Cycle Management, who will review the documentation submitted and make a determination based on this policy's criteria. The Executive Director of Revenue Cycle Management's decision is final, and patients who appeal an initial determination will receive a final appeal determination letter thirty days prior to any additional collection efforts.

6. Financial assistance awards apply to all open accounts at the time of the financial assistance award and are valid for six months from the date of the financial assistance award for non-Medicare patients and for one year for Medicare patients.

7. Patients with open accounts less than $100 in totality are not eligible for financial assistance.

8. Accounts previously sent to GBMC's Collections Department and written-off as bad debt will not be eligible for financial assistance and will remain bad debt.

C. **COLLECTION EFFORTS:** The billing cycle will initiate fifteen 15 days after date of the denial letter. Three (3) billings statements are sent in 30-day intervals in attempt to collect the outstanding amounts. If there is no collection or payment arrangements made, the outstanding amounts are sent to a collection agency. If a patient files for bankruptcy during the financial assistance application process, award period, or during any collection efforts, the patient should provide written notification from the U.S. Bankruptcy Court to the GBMC Collection Manager.

D. **FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA**

1. For each patient, the percentage of the current Federal Poverty Level ("FPL") will be calculated, based on modified adjust gross income, as defined in the Federal Poverty Guidelines, and family size.

2. For patients 300% FPL or lower, GBMC will provide 100% financial assistance for Eligible Services if

the patient and adult household members have Liquid Assets of $15,000 or less.

3. For patients 301%-500% FPL, GBMC will provide 50% financial assistance for Eligible Services if the patient and adult household members have Liquid Assets of $15,000 or less.
4. For patient's 501% FPL, financial assistance will not be provided by GBMC.

E. **EXCLUSION CRITERIA**

1. Uninsured and under-insured patients who do not meet the financial assistance criteria.
2. Patients who have insurance and chose self-pay for Eligible Services.
3. Patients seeking assistance for non-medically necessary services, including cosmetic procedures.
4. Non-United States citizens and non-Maryland residents.
5. Patients who are non-compliant with enrollment for publicly funded healthcare programs, charity care programs and other forms of financial assistance.
6. Patients who fail to provide accurate and complete financial information within the time frames stated in this FAP.

F. **ASSUMPTIVE FINANCIAL ASSISTANCE:** Assumptive Financial Assistance is a program run in partnership with the TransUnion credit reporting agency. Self-pay accounts for Maryland residents are referred to TransUnion, who utilizes a proprietary credit scoring system to determine the likelihood and ability to pay based on estimated income and family size. The results from the TransUnion credit score are compared to GBMC's Financial Assistance eligibility criteria and a decision is made to write off or to pursue collection on certain accounts.

G. **PAYMENT PLANS**

1. If a patient does not qualify for financial assistance, he/she may request a payment plan of equal monthly payments to pay the balance in full over a maximum of eighteen (18) months, with minimum monthly payments no less than twenty-five ($25) dollars per month.
2. Payment plans are not available for outstanding accounts less than $100.
3. If approved for a payment plan, a patient is set up under a contract in GBMC's medical record system, Epic, and monthly statements will be generated and sent to the patient, indicating the monthly payment amount, due date and balance.
4. Failure to pay under a payment plan by the due date will result in termination of the payment plan and the delinquent account will be sent to the GBMC Collection Manager for collection efforts after a final demand letter is sent and thirty days (30) from the date of the demand letter have passed.

Exhibit A

Listing of GBMC Practices

Services Provided in Practices are Covered under the FAP

GBMC Health Partners Medicine Intensivist
GBMC Health Partners Gastroenterology Clinical Practice
GBMC Health Partners Pulmonary Medicine
GBMC Health Partners Sleep Medicine at GBMC
GBMC Health Partners Infectious Disease
GBMC Health Partners Center for Neurology
GBMC Health Partners Medicine Hospitalist
GBMC Health Partners Internal Med Faculty Practice
GBMC Health Partners Clinical Genetics
GBMC Health Partners Thoracic Surgeons
GBMC Health Partners Medical Oncology
GBMC Health Partners Dr. Schnaper Clinical Practice
GBMC Health Partners Joppa Road Practice
GBMC Health Partners GBMC Medicine for Adults
GBMC Health Partners Perry Hall
GBMC Health Partners Texas Station Clinical Practice
GBMC Health Partners Jarrettsville
GBMC Health Partners Care Coordination
GBMC Health Partners Family Care at OM
GBMC Health Partners Family Care Clinical Practice
GBMC Health Partners Outreach - Hunt Manor
GBMC Health Partners Medicine - Owings Mills
GBMC Health Partners Clinical Practice - Hunt □alley
GBMC Health Partners Palliative Medicine
GBMC Health Partners Community Benefit Senior Outreach
GBMC Health Partners Geriatric Practice
GBMC Health Partners Bariatric Surgery
GBMC Health Partners Neurosurgical Clinical Practice
GBMC Health Partners Finney Trimble
GBMC Health Partners Ophthalmology Clinic
GBMC Health Partners Ortho Spec of MD at GBMC
GBMC Health Partners □ein Center
GBMC Health Partners Hoover Low □ision
GBMC Health Partners Ophthalmology Residency
GBMC Health Partners Clinical Practice Ophthalmology
GBMC Health Partners Cochlear Implant Program
GBMC Health Partners OB/GYN Practice
GBMC Health Partners GYN Oncology CP
GBMC Health Partners Perinatal Associates
GBMC Health Partners Women’s Diagnostic Clinic

GBMC Health Partners Pediatric Associates
GBMC Health Partners NICU Hospitalists
GBMC Health Partners Pediatrics Hospitalists
GBMC Health Partners OB Hospitalists
GBMC Health Partners Dr. Hinton Clinical Practice
GBMC Health Partners Pre-Natal Diagnostic Program
GBMC Health Partners GYN Clinical Practice
GBMC Health Partners Dr. Hebb Practice
GBMC Health Partners Dr. Doran Clinical Practice
GBMC Health Partners Community Benefit Services
GBMC Health Partners Chesapeake Urology Infusion
GBMC Health Partners HSCRC Transformation Grant
GBMC Health Partners ound Care Center
GBMC Health Partners Hyperbaric Oxygen Unit
GBMC Health Partners Outpatient Rehab Medicine
GBMC Health Partners Electrocardiology
GBMC Health Partners Medical Residency Program
GBMC Health Partners Diabetes Center
GBMC Johns Hopkins oice Center
GBMC Johns Hopkins Head and Neck Surgery
GBMC Health Partners Otolaryngology Clinic
GBMC Health Partners GBMC Mid-Level Providers
GBMC Health Partners Hearing and Speech
GBMC Health Partners Pre-Surgical Testing
GBMC Health Partners ENT Residency
GBMC Health Partners OB Clinic

Maryland State Uniform Financial Assistance Application

Information About You

□ame: _____
First *Middle Initial* *Last*

□ocial □ec□rity □□mber ☐☐☐ ☐☐☐ ☐☐☐☐ Marital □tat□s: ☐ □ingle ☐ Married ☐ □eparated

□□Citi□en: ☐ □es ☐ □o Permanent Resident: ☐ □es ☐ □o

□ome Address: _____
Street Address
_____
City *State* *Zip code* *Country*

□ome Phone:
☐☐☐ ☐☐☐ ☐☐☐☐
□*Area Code) ### - ####*

□mployer □ame □ Address: _____
Employer Name
_____
Street Address
_____
City *State* *Zip code*

□ or □Phone:
☐☐☐ ☐☐☐ ☐☐☐☐
□*Area Code) ### - ####*

□o□sehold Members:

Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*
Name	*Age*	*Relationship*

□ave yo□applied for Medical Assistance ☐ □es ☐ □o

□f yes□□hat □as the date yo□applied□ ☐☐/☐☐/☐☐☐☐ *(MM/DD/YYYY)*

□f yes□□hat □as the determination□

□o yo□receive any type of state or co□nty assistance□ ☐ □es ☐ □o

□ospital □ame
Ret□rn Address

I. Family Income

□ist the amo□nt of yo□r monthly income from all so□rces. □o□ may be re□□ired to s□pply proof of income□assets□and e□penses. □f yo□have no income□please provide a letter of s□pport from the person providing yo□r ho□sing and meals.

	Monthly Amount
□mployment	
Retirement/pension benefits	
□ocial sec□rity benefits	
P□blic assistance benefits	
□isability benefits	
□nemployment benefits	
□eterans benefits	
Alimony	
Rental property income	
□tri□e benefits	
Military allotment	
Farm or self employment	
Other income so□rce:	
Total	

II. Liquid Assets

	Current Balance
Chec□ing acco□nt	
□avings acco□nt	
□toc□s□bonds□C□□or money mar□et	
Other acco□nts	
Total	

III. Other Assets

□f yo□o□n any of the follo□ing items□please list the type and appro□imate val□e.

□ome :	□oan Balance:			Appro□imate val□e:	
A□tomobile:	Ma□e:		□ear:	Appro□imate val□e:	
Additional vehicle:	Ma□e :		□ear:	Appro□imate val□e:	
Additional vehicle:	Ma□e:		□ear:	Appro□imate val□e:	
Other property:				Appro□imate val□e:	
				Total	

IV. Monthly Expenses

	Amount
Rent or Mortgage	
□tilities	
Car payment□s□	
Credit card□s□	
Car ins□rance	
□ealth ins□rance	
Other medical e□penses	
Other e□penses	
Total	

□o yo□have any other □npaid medical bills□ ☐ □es ☐ □o

For □hat service□ _____

□f yo□have arranged a payment plan□□hat is the monthly payment□ _____

□f yo□re□□est that the hospital e□tend additional financial assistance□the hospital may re□□est additional information in order to ma□e a s□pplemental determination. By signing this form□yo□certify that the information provided is tr□e and agree to notify the hospital of any changes to the information provided □ithin ten days of the change.

Applicant signature *Date* *Relationship to Patient*

Exhibit C

Greater Baltimore Medical Center
Patient Financial Services
100 West Road
Suite 500
Towson, MD 21204

Due back on or before: _____

PATIENT INFORMATION SHEET AND FULLFILLMENT REQUIREMENTS

Thank you for inquiring about our Financial Assistance Program. Everyone is eligible to apply. The Financial Assistance Application you have been given will need to be completed and returned to us.

Please provide any of the following information that applies to your situation:

- 2 recent pay stubs for each family member 18 years or older including date of hire
  Please note your status on your pay stubs (full time, part time, number of hours per week)
  Please also note how you are paid (weekly, bi-weekly or bi-monthly)
- 2 most recent unemployment insurance pay stubs
- A copy of your most recent income tax returns **(Federal and State) with W2's (all pages)**
- A copy of your current Social Security Award Letter
- A copy of your Medical Assistance/Food Stamps or Cash Assistance denial or approval letter
- A complete copy of your 2 most recent checking and savings account statements **(all pages)**
  Bank statements must include account holder name(s), account number(s) and daily balance(s)
- A copy of your 2 most recent investment statements (Money Market CDs Stocks etc.)
- A letter of hardship briefly explaining your need for financial assistance
- If you do not have any income a notarized letter from the person providing your support is required (depending upon the situation additional information may be requested

Failure to return the above information that is applicable to your situation may prevent us from considering your Financial Assistance application. Please explain in your letter of hardship your reason for not supplying any of the above information.

The attached "Medical Assistance Screening Check List" also needs to be completed. This document helps us to determine if you may be eligible for additional programs. Please make sure you sign and date your application and return your application to the address shown above.

Representatives are available Monday through Friday from 8:00 AM to 5:00 PM. Please feel free to contact us at (443) 849-2450 (press 1) or at (800) 626-7766 (press 1). **We look forward to assisting you with your application process.**

Sincerely,

The Patient Financial Services Department