POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entity: Sibley Memorial Hospital (SMH).

Sibley Memorial Hospital 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 medically necessary care based on their individual financial situation. Sibley Memorial Hospital will not engage in any extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for financial assistance under this policy. Individuals eligible for financial assistance will not be expected to pay more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care.

The purpose of this policy is to outline a program of financial assistance in compliance with the District of Columbia statutory uncompensated care requirements as described in Chapter 44 of the DC Municipal Regulations, Title 22 and to provide financial assistance to persons who submit an application for assistance but do not meet the guidelines for “Provision of Uncompensated Care” under Chapter 44 of the DC Municipal Regulations, Title 22.

Sibley Memorial Hospital (“Hospital”) will put forth a good faith effort to provide uncompensated services at the annual compliance level required by section 4404 of Chapter 44 of the District of Columbia Municipal Regulations, Title 22 “Provision of Uncompensated Care.”

In no event will Sibley deny emergency services to any person without discrimination on the grounds that the person is unable to pay for services. Sibley may discharge a person who has received emergency services or may transfer the person to another facility when, in the reasonable judgment of appropriate medical personnel, such action is clinically appropriate and in the best interest of the patient and the hospital.

Sibley will provide uncompensated care pursuant to Section 4400.2 of Chapter 44 of the District of Columbia Municipal Regulations, Title 22, “Provision of Uncompensated Care,” to eligible persons. The uncompensated care to be provided shall be based upon these rules or contractual obligations between Sibley and the District of Columbia Government, whichever standard provides the higher dollar value.

Uncompensated care is defined in the law governing certificate of needs (DC Code 44-401 in the definitions section). The law defines uncompensated care as the cost of health care services rendered to patients for which the health care facility does not receive payment. The term “uncompensated care” includes bad debt and charity care, but does not include contractual allowances.

Bad debt means an account receivable based on physician and hospital medical services furnished to any patient for which payment is expected, but is regarded as uncollectible, following reasonable collection efforts; and not the obligation of any federal, state, or local governmental unit. The term bad debt does not include charity care.

Charity Care means the physician and hospital medical services provided to persons who are unable to pay for the cost of services, especially those persons who are low-income, uninsured and underinsured, but excluding those services determined to be caused by, or categorized as, bad debt.

For the purpose of this policy, uncompensated care to be provided shall be calculated as follows:

Annual compliance level:
An amount not less than three (3%) percent of Sibley’s annual operating expense, less the amount of reimbursements it receives from Titles XVIII and XIX of the Social Security Act (Medicaid and Medicare), without regard for contractual allowances. In addition, Sibley shall comply with any uncompensated care
obligations required pursuant to the Act in a previous CON.

If in any fiscal year Sibley fails to meet its annual uncompensated care obligation, then it shall endeavor to provide uncompensated care in an amount sufficient to make up the deficit in a subsequent year or years, pursuant to a compliance plan approved by the State Health and Planning Development Agency (hereafter SHPDA) but not later than three (3) years after the year in which the deficit occurred.

If Sibley provides uncompensated care during a fiscal year in an amount exceeding its annual compliance level, Sibley may request that the Director apply the excess amount as a credit towards an existing deficit or its annual compliance level for any subsequent fiscal year. To be eligible for a credit, the excess dollar value above the annual compliance level must have been provided pursuant to the requirements of this chapter.

**Published Notice of Uncompensated Care Obligation:**
Before the beginning of its fiscal year, Sibley will publish a notice of availability of its uncompensated care obligation in a newspaper of general circulation in the District of Columbia. Sibley will also submit a copy of such notice to SHPDA. The Senior Vice President/Chief Financial Officer is responsible for the publishing and submission of this notice. The notice shall include:

a) The dollar value of uncompensated care that Sibley intends to make available during the fiscal year or a statement that Sibley will provide uncompensated care to all persons unable to pay for treatment who request uncompensated care;

b) An explanation of the difference between the amount of uncompensated care Sibley proposes to make available and the annual compliance level for Sibley, if any; and

c) A statement indicating whether Sibley has satisfied all outstanding uncompensated care obligations from previous reporting periods, or a statement indicating that it will, during a specific period, satisfy any outstanding obligation.

**Posted Notice of Availability of Uncompensated Care:**
A notice announcing the availability of uncompensated care shall also be posted in plain view in the patient registration sites, Admissions Department, the Business Office and the Emergency Department. Sibley shall post the following notice:

"Under District of Columbia law, this health care provider must make its services available to all people in the community. This health care provider is not allowed to discriminate against a person because of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source income, or place of residence or business, or because a person is covered by a program such as Medicare or Medicaid."

"This health care provider is also required to provide a reasonable volume of services without charge or at a reduced charge to persons unable to pay. Ask the staff if you are eligible to receive services either without charge or at a reduced charge. If you believe that you have been denied services or consideration for treatment without charge or at a reduced charge without good reason, contact the Admissions or Business Office of this health care provider, and call the State Health Planning and Development Agency through the Citywide Call Center at 202-727-1000."

"If you want to file a complaint, forms are available from the State Health Planning and Development Agency."

This notice shall also include a summary of Sibley’s eligibility criteria for uncompensated care. Such notice shall be published in English and Spanish and in any other language which is the usual language of households of ten (10%) percent or more of the populations of the District of Columbia, according to the most recent figures as published by the Bureau of Census. Sibley
shall communicate the contents of the posted notice to any person who Sibley has reason to believe cannot read the notice.

**Written Notice of Availability of Uncompensated Care:**

In any period during a fiscal year in which uncompensated care is available at Sibley, Sibley shall provide written notice of the availability of the services to each person who seeks services from the hospital on behalf of himself or herself or on behalf of another. Sibley will provide this written notice before providing services, except where the emergency nature of services makes prior notice impractical. In emergency situations, Sibley shall provide the written notice to the patient as soon as practical, or to the next of kin. Such notice shall be given not later than when presenting the first bill of services. This individual written notice shall provide the following:

"Under the District of Columbia law, this health care provider must make its services available to all people in the community. This health care provider is not allowed to discriminate against a person because of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source of income, or place of residence or business, or because a person is covered by a program such as Medicare or Medicaid."

"This health care provider is also required to provide a reasonable volume of services without charge or at a reduced charge to persons unable to pay. Ask the staff if you are eligible to receive services either without charge or at a reduced charge. If you believe that you have been denied services or consideration for treatment without charge or at a reduced charge without a good reason, contact the Admissions or Business Office of this health care provider, and call the State Health Planning and Development Agency through the Citywide Call Center at 202-727-1000."

"If you want to file a complaint, forms are available from the State Health Planning and Development Agency."

This notice shall also include a summary of Sibley’s eligibility criteria for uncompensated care, the location of the office where any person seeking uncompensated care may request uncompensated care, and state that Sibley shall make a written determination regarding whether or not the person will receive uncompensated care and the date by, or period within which, the determination will be made. For an example of this form, see Exhibit D.

**Written Determination of Eligibility for Uncompensated Care:**

Sibley will give written notice of its determination of eligibility for uncompensated care in response to each request for uncompensated care to the person requesting care. Notice shall be given in person at the time uncompensated care is requested or by regular mail to the address the person requesting service provided. If the person is not available to receive notice in person and has not provided an address, Sibley may post at its facility, in a conspicuous place, a notice that the person’s eligibility status is available in the administrative office of Sibley.

Each written determination of eligibility for uncompensated care shall be made promptly to the applicant. Each determination of eligibility for uncompensated care shall include the following statements:

- a) That Sibley will, will with conditions, or will not provide uncompensated care;
- b) That there will be no charge for uncompensated care;
- c) The date on which the person requested care;
- d) The date on which the determination was made;
- e) The annual individual or family income, as applicable, and family size of the person who requested uncompensated care;
- f) The date on which services were, or will be, provided; and
- g) The reason for denial, if applicable.
If an application is submitted prior to the provision of service, Sibley shall make an eligibility determination for uncompensated care within five (5) business days of a complete request for an outpatient service or before discharge for an inpatient service. If the application is submitted after an outpatient service is rendered by the Hospital or after the discharge of an inpatient, Sibley shall make eligibility determination before the completion of the next billing cycle. Normally, the notice of determination will be made within 5 days of the next scheduled meeting of the Community Assistance Committee. Sibley may issue a conditional eligibility determination. Such determination shall state the conditions that the person requesting uncompensated care must satisfy to be eligible.

The Senior Vice President/Chief Financial Officer is responsible for implementing this policy. He/she shall prepare an allocation plan that meets the requirements of the regulations and monitor its implementation. The Senior Vice President/Chief Financial Officer will prepare a report to the SHPD in 120 days after close of each fiscal year. Documents that support Sibley's determination shall be made available to the public and reported to SHPD. Such reports shall be maintained by the Senior Vice President/Chief Financial Officer for a period of five (5) years from the date of the last entry for a particular fiscal year. The President and the Treasurer of the Board shall be kept informed on a periodic basis of Sibley’s compliance with the policy.

**Definition of the Hospital’s Community:**

Sibley Memorial Hospital makes its services, including services required under the District of Columbia statutory uncompensated care requirements “to all persons in the community.” This community extends to those persons living or working in the hospital’s service area or requiring emergency services while otherwise visiting within the service area. Specifically excluded from the Community Assistance Program are those persons requesting elective services who clearly reside outside of the hospital’s service area. The hospital’s service area encompasses the District of Columbia and most of Maryland and Virginia, with limited services provided to residents of West Virginia, Delaware and Pennsylvania. The hospital may request the applicant to provide documentation demonstrating compliance with the hospital’s definition of community.

Sibley Memorial Hospital will publish the availability of Financial Assistance on a yearly basis in their local newspaper, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department. Notice of availability will be posted on the hospital website, will be mentioned during oral communication and will also be sent to patients on or with patient bills. A summary of the hospital’s Financial Assistance Policy 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. This should include a review of the patient’s existing medical expenses and obligations (including any accounts placed in bad debt except those accounts on which a lawsuit has been filed and a judgment obtained) and any projected medical expenses. Financial Assistance Applications 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.

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

Attached as EXHIBIT E is a list of physicians that provide emergency and medically necessary care as defined in this policy at SMH. 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 Hopkins hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles. 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 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 nonqualified 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 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.

Individuals eligible for financial assistance will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care.
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.
- A patient is referred to the hospital to receive services under the Financial Assistance program by a charitable clinic or other organization, such as Catholic Charities

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 will meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   a. All hospital applications will be processed within five (5) business days of a complete request for an outpatient service or before discharge for an inpatient service and a determination will be made as to probable eligibility. If the application is submitted after an outpatient service is rendered by the Hospital or after the discharge of an inpatient, Sibley shall make eligibility determination before the completion of the next billing cycle. Normally, the notice of determination will be made within 5 days of the next scheduled meeting of the Community Assistance Committee. Sibley may issue a conditional eligibility determination. Such determination shall state the conditions that the person requesting uncompensated care must satisfy to be eligible. 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, the Hospital will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.

   b. Applications received will be sent to the Sibley Financial Counselors or JHHS Patient Financial Services Department’s dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.

4. To determine final eligibility, the following criteria must be met:

   a. 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. 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. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.
c. All insurance benefits must have been exhausted.

5. To the extent possible, there will be one application process. The patient is required to provide the following, if applicable:

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. 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 in the definitions section. 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 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 to the Community Assistance Committee 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 Community Assistance Committee. This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Committee will have a final determination made no later than 30 days from the date the application was considered complete. The Community Assistance Committee will base its 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 patients do not qualify for Financial Assistance.

9. 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 make 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, Sibley 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.

10. 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 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. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipient of the means-tested social service programs are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Appendix A-1 provides a list of life circumstances that qualify a patient for Presumptive Eligibility.

11. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. 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 Financial Assistance Evaluation Committee. 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.

12. If a patient account has been assigned to a collection agency, and patient or guarantor request 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.

13. 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.
FINANCIAL ASSISTANCE

RESPONSIBILITIES – SMH

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

On the day initial application is received, fax to Patient Financial Services Department’s dedicated fax line for determination of probable eligibility.

Review preliminary application, Patient Profile Questionnaire and Medical Financial Hardship Application (if submitted) to make probable eligibility determination. Within five business days of receipt of initial application (or before discharge for an application received during an inpatient admission), 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.

REFERENCE

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

Federal Poverty Guidelines (Updated annually) in Federal Register

1¹ 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.
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 5 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 or Financial Assistance recipients.

Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent)
The Community Assistance Committee
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
Senior Director, Patient Finance (JHHS)
Senior Director, Revenue Cycle (SMH)

REVIEW CYCLE
Two (2) years

APPROVAL

Sr. VP of Finance/Treasurer & CFO for JHH and JHHS
Date
1. Each person requesting Financial Assistance must complete a Sibley 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.

5. 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.

6. Patients will be eligible for Financial Assistance if their maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed Sibley’s standard (related to the Federal poverty guidelines).

7. All insurance resources and other entitlement and similar program 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.

8. 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.

9. 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 "elective" or "necessary," the patient’s admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by the hospital.

10. Each affiliate will determine final eligibility for Financial Assistance within five (5) business days of the day when the application was satisfactorily completed and submitted or prior to discharge if the application was received during an inpatient admission.

11. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.
12. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application 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. However, eligibility criteria and benefit level may vary by affiliate.

13. All determinations of eligibility for Financial Assistance shall be solely at the discretion of Sibley Memorial Hospital

**Exception**

The Senior Director of Revenue Cycle (or affiliate equivalent) may make exceptions according to individual circumstances.
## FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

### TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCE

**Effective 3/1/16**

<table>
<thead>
<tr>
<th># of Persons in Family</th>
<th>Upper Limits of Family Income for Allowance Range</th>
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<tbody>
<tr>
<td></td>
<td>FPL X 1</td>
<td>FPL X 2</td>
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<tr>
<td>1</td>
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<td>8*</td>
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<td>$81,780</td>
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For Each Add'l Family Member Add: $4,160 $8,320 $12,480 $16,640

<table>
<thead>
<tr>
<th>Allowance</th>
<th>Expected Payment</th>
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<tbody>
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<td>0%</td>
</tr>
<tr>
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<td>0%</td>
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<td>95% of AGB</td>
</tr>
<tr>
<td>100% - AGB</td>
<td>AGB</td>
</tr>
</tbody>
</table>

The amounts generally billed to individuals with insurance “AGB” will be calculated using the "look-back method" which is defined as all claims for emergency and other medically necessary care that have been paid in full to the hospital by Medicare and all private health insurers together as the primary payers of these claims, in each case taking into account amounts paid to the hospital in the form of coinsurance or deductibles. Sibley will calculate the AGB percentage(s) at least annually by reviewing all claims paid in full during a preceding 12 month period. Once determined, the AGB percentage(s) will be implemented no later than 45 days after the end of a 12 month period.
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
- Primary Adult Care Program (PAC) coverage
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Public Health System Emergency Petition patients
- Participation in Women, Infants and Children Programs (WIC)
- Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility
- Eligibility for other state or local assistance programs which have financial eligibility at or below 200% of FPL
- Patient is deceased with no known estate
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 100% 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

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, Sibley 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 treatment 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.

The patient/guarantor can request that such a determination be made by submitting a Medical Financial Hardship Assistance Application (Exhibit C), when submitting Sibley 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 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.
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 Sibley 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 Hopkins 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

Exception

The Senior Director of Revenue Cycle or designee of Patient Financial Services (or affiliate equivalent) 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.
MEDICAL HARDSHIP FINANCIAL GRID

### TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

**Effective 3/1/16**

<table>
<thead>
<tr>
<th># of Persons in Family</th>
<th>Income Level**</th>
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<tbody>
<tr>
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<td>*300% of FPL</td>
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<tr>
<td>1</td>
<td>$35,640</td>
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<tr>
<td>2</td>
<td>$48,060</td>
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<tr>
<td>3</td>
<td>$60,480</td>
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<tr>
<td>4</td>
<td>$72,900</td>
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<td>5</td>
<td>$85,320</td>
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<td>6</td>
<td>$97,740</td>
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<tr>
<td>7</td>
<td>$110,190</td>
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<tr>
<td>8*</td>
<td>$122,670</td>
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For Each Add'l Family Member Add:

|                            | $12,480      | $16,640     | $20,800     |

Expected Payment Capped At: 25% of Gross Family Income
REQUEST FOR DETERMINATION
OF ELIGIBILITY FOR
UNCOMPENSATED SERVICES

NOTICE: PROVISIONS OF UNCOMPENSATED CARE AND COMMUNITY SERVICES

Under District of Columbia law, this health care provider must make its services available to all people in the community. This health care provider is not allowed to discriminate against a person because of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source of income, or place or residence or business, or because a person is covered by a program such as Medicare or Medicaid.

This health care provider is also required to provide a reasonable volume of services without charge or at a reduced charge to persons unable to pay. Ask the staff if you are eligible to receive services without charge or at a reduced charge. If you believe that you have been denied services or consideration for treatment without charge or at a reduced charge without good reason, contact the Admissions or Business Office of this health care provider, and call the State Health Planning and Development Agency through the Citywide Call Center at 202-727-1000.

If you want to file a complaint, forms are available from the State Health Plan Development Agency.
REQUEST FOR DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED SERVICES

DATE OF REQUEST: __________________________

PATIENT’S NAME: ___________________________ DATE OF BIRTH: ______________

SPOUSE’S NAME: ___________________________ DATE OF BIRTH: ______________

ADDRESS: __________________________________

TELEPHONE NUMBER: ________________________ EMAIL: ________________________

PATIENT’S SOCIAL SECURITY NUMBER: ________________________________________

SPOUSE’S SOCIAL SECURITY NUMBER: ________________________________________

DEPENDENTS:

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<tr>
<th>NAME</th>
<th>AGE</th>
<th>RELATIONSHIP TO PATIENT</th>
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INCOME (MONTHLY)

WAGES: _______________ PENSIONS: _______________

PUBLIC ASSISTANCE: _______________ INTEREST: _______________

SOCIAL SECURITY: _______________ DIVIDENDS: _______________

UNEMPLOYMENT COMPENSATION: _______________ WORKER’S COMPENSATION: _______________

ALIMONY: _______________ OTHER: _______________

CHILD SUPPORT: _______________ OTHER: _______________

RENTS: _______________ OTHER: _______________
EMPLOYMENT:

NAME OF PATIENT'S EMPLOYER: __________________________________________

ADDRESS OF PATIENT'S EMPLOYER: ______________________________________

PATIENT'S EMPLOYER TELEPHONE NUMBER: ________________________________

NAME OF SPOUSE'S EMPLOYER: _________________________________________

ADDRESS OF SPOUSE'S EMPLOYER: ______________________________________

SPOUSE'S EMPLOYER TELEPHONE NUMBER: ________________________________

HOSPITAL INSURANCE: (INCLUDING MEDICARE, MEDICAID, COMMERCIAL)

NAME OF INSURANCE COMPANY: _________________________________________

GROUP NUMBER: ___________________________ POLICY NUMBER: ______________

NAME OF INSURANCE COMPANY: _________________________________________

GROUP NUMBER: ___________________________ POLICY NUMBER: ______________

ASSETS: (PLEASE CHECK APPROPRIATE ONES)

CASH / CHECKING / SAVINGS ACCOUNTS……………………………………………… VALUE: $ _______________________

STOCKS / BONDS / CERTIFICATES……………………………………………… VALUE: $ _______________________

REAL ESTATE…………………………………………… VALUE: $ _______________________

OTHER (CAR, MOBILE HOME, BOATS, ETC.,)……………………………… VALUE: $ _______________________

DESCRIPTION OF "OTHER": _______________________________________________
<table>
<thead>
<tr>
<th>NAME OF CREDITOR</th>
<th>MONTHLY PAYMENT</th>
<th>UNPAID BALANCE</th>
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I, THE UNDERSIGNED, REQUEST SIBLEY MEMORIAL HOSPITAL MAKE A DETERMINATION OF MY ELIGIBILITY FOR UNCOMPENSATED SERVICES.

I AUTHORIZE SIBLEY MEMORIAL HOSPITAL TO INVESTIGATE, BY ANY MEANS INCLUDING MY EMPLOYER AND CREDIT CONFIRMATIONS THROUGH REPORTING AGENCIES, MY FINANCIAL CONDITIONS.

I ALSO UNDERSTAND THAT IF ANY INFORMATION I SUBMIT IS DETERMINED TO BE FALSE, SUCH DETERMINATION MAY RESULT IN A DENIAL AND WILL BE HELD LIABLE FOR ALL CHARGES.

ACCEPTANCE OF THIS APPLICATION BY SIBLEY MEMORIAL HOSPITAL DOES NOT GUARANTEE GRANTING OF UNCOMPENSATED CARE.

APPLICANT’S SIGNATURE: ________________________  DATE: ________________________
Medical Care for Those Who Cannot Afford to Pay

Sibley Memorial Hospital Community Assistance Program

Under District law, Sibley Memorial Hospital has an obligation to make its services available to all people in the community. Sibley Memorial Hospital is not allowed to discriminate against a patient or applicant for services because of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source of income, or place of residence or business, or because a patient or applicant for services is covered by a program such as Medicare or Medicaid. Sibley Memorial Hospital is also obligated to provide a reasonable volume of services without charge or at a reduced charge to persons unable to pay.

If you would like to apply for financial assistance concerning your hospital bill, please contact the Financial Counselors located in the Admissions Department at 202-537-4160 or 202-537-4161. You will be required to fill out an application that includes information about your family size, family income, family expenses and other personal data. This information will be reviewed and a decision will be made by a committee. Hospital criteria will use the Federal Poverty Guidelines in determining your eligibility for financial assistance. A written determination of your eligibility will be sent to you within 30 days after the hospital receives a complete application with all requested documentation. Individuals eligible for financial assistance will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care.

If you believe that you have been improperly denied services, contact the Financial Counselors Office of Sibley Memorial Hospital at 202-537-4160 or 202-537-4161, or call the District Health Planning and Development Agency (SHPDA) at 202-442-5875.
(or such other telephone number as the SHPDA may designate by notifying the health care provider in writing).
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 B
Monthly Payment Amount:__________________  Length of Payment
Plan:___________month
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:

<table>
<thead>
<tr>
<th>Date of service</th>
<th>Amount owed</th>
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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.

_________________________________________ Date: ______________________
Applicant’s signature

Relationship to Patient

For Internal Use: 
Reviewed By: 

Income: ________________ 25% of income= ________________

Medical Debt: ________________ Percentage of Allowance: ________________

Reduction: ________________

Balance Due: ________________