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**POLICY SCOPE:**

**This policy applies to The Johns Hopkins Health System Corporation (JHHS) and the following affiliated entity: Johns Hopkins Community Physicians (JHCP).**

Purpose

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance.

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.


A determination of Financial Assistance will be re-evaluated every six (6) months as necessary.

**PROCEDURES**


1. An evaluation for Financial Assistance can be commenced in a number of ways.

For example:

- 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.
  - 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 charity care evaluation for potential admission.
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. When a patient requests Financial Assistance, the staff member who receives the request will refer the patient to the designated person in their clinical or business unit, who will meet with the patient. An assessment will be done to determine if patient meets preliminary criteria for assistance.
  4. The following criteria must be met in order for a patient to apply 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 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. Review viability of offering a payment plan agreement.
    - c. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.

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- d. All insurance benefits have been exhausted.
5. There will be one application process for all of Johns Hopkins Medicine. The patient is required to provide the following:
  - a. A completed Financial Assistance Worksheet (see example in Appendix 1).
  - 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).
  - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income (and spouse's if applicable).
  - d. A Medical Assistance Notice of Determination (if applicable).
  - e. Proof of disability income (if applicable).
  - f. Reasonable proof of other declared expenses.
6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor taking the application will review and analyze the application based on JHCP guidelines.
  - a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Counselor will recommend the patient's level of eligibility.
  - b. If the patient's application for Financial Assistance is based on excessive medical expenses 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 Sr. Director of the Business Operations department for review. It is expected that an application for Financial Assistance, which is reviewed by the Sr. Director will have a final determination made no later than 30 days from the date it was considered complete.
7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
8. A department can continue using an adjustment to total charges (sliding scale) without the completion of Financial Need Assessment paperwork if the sliding scale gives adjustment, which is consistent with the Adjustments and Courtesy for Clinical Services policy. The use of a sliding scale in this manner only applies to the specific physician and service involved. It does not automatically apply to any other physician or service at Johns Hopkins.
9. A department can continue to use a government sponsored application process and associated income scale, as it is required by terms of a program grant or other outside authority governing that program. (i.e.: JHH Community Psychiatry Program).
10. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to Johns Hopkins. 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.

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11. 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 designated director.

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

**JHHS Finance Policies and Procedures Manual**

Policy No. FIN017 - Signature Authority: Patient Financial Services

Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Federal Poverty Guidelines (Updated annually) in Federal Register

**RESPONSIBILITIES - JHCP**

Financial Counselor Customer Service Collector, Any Finance representative designated to accept applications for Financial Assistance

- Understand current criteria for Assistance qualifications.
- Identify prospective candidates; initiate application process.
- Review and ensure completion of application.
- Deliver completed application to appropriate management.
- Document all transactions in all applicable patient account's comments.
- Identify retroactive candidates; initiate application process.
- Review and ensure completion of application.
- Deliver completed application to Patient Financial Services management.


Management Personnel  
(Supervisor/Manager/Director)

- Review completed application; determine patient eligibility; communicate final written determination to patient.
- Advise ineligible patients of other alternatives available to them including Medical Assistance, installment payments, bank loans, or consideration under the catastrophic program. [Refer to Appendix B - Catastrophic Financial Assistance Guidelines.

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

- Review and approve Financial Assistance applications in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

<sup>1</sup> NOTE: Standardized applications for financial assistance have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibit A.

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**SPONSOR**

Vice President/Chief Financial Officer and Treasurer, JHHS

**REVIEW CYCLE**

Three (3) years


**APPROVAL**

\_\_\_\_\_  
President, JHHS/JHH

\_\_\_\_\_  
Date

**PROCEDURES – JHCP**


1. Financial Counseling Staff
  - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
  - b. Approve/disapprove applications and return finalized applications to Director, Patient Financial Services.
  
2. Site/Clinical – Staff
  - a. Refer patients (or guarantors) to Financial Counseling when evidence of need for Financial Assistance is indicated and patient's financial status does not indicate current eligibility for Sliding Scale programs. Potential referral situations include:
    - 1) Attempts to collect for non-covered services during the Check-In or Post Service -- the patient is unable to pay.
    - 2) Patient is informed, during the appointment or pre-verification process, of his/her obligation to pay for non-covered services and/or the patient has an outstanding "Self-Pay" balance and indicates that they are unable to pay.
  - b. Code the visit as "Self-Pay" if the referral to Financial Counseling is made on the date of the visit, or after the service has been provided.
  - c. Use the "Sliding Fee Adjustment Scale" at the approved adjustment to determine the amount to be collected at point-of-service from those patients who are currently eligible for the sliding scale program.
  - d. Review the patient/guarantor's current financial status as follows:

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- 1) Use a current Sliding Scale Financial Status Code (i.e., the termination date has not been reached) as indication that patient has qualified for the adjustment.
- 2) Use Sliding Scale Financial Status Code as the Primary Financial Status Class for the current visit when the Sliding Scale Financial Status Code is present on patient's record and there are no other valid fee-for-service Financial Status Codes, and the care is within the effective termination dates.
  - a) Sliding Fee will always be secondary to fee-for-service coverage.
  - b) Patient must reapply if the care being rendered is past the Sliding Fee Financial Status Class termination date.
- e. Assist patient in supplying the necessary information and confirming data for a new JHCP Financial Assistance Application, if applicable.


The following confirming data is required for approval of JHCP - sponsored Financial Assistance:

- 1) Income Verification
  - a) Two (2) most recent pay stubs for patient and/or spouse; or
  - b) Two (2) most recent Unemployment check stubs; or
  - c) Social Security check stub.
2. Evidence of Family Size
  - a) A copy of the previous year's Federal Income tax Return
  - b) A copy of the Birth Certificate for each family dependent.
3. Patient
  - a. Apply for Sliding Fee adjustments, by one of the following methods:
    - 1) Visit any JHCP site. Applications presented in person at sites other than Wyman Park should be sent by Inter-Office Mail to the Business Office at Wyman Park, Attention: Financial Counseling Department.
    - 2) Mail an application, with all required information, to the Business Office at Wyman Park, Attention: Financial Counseling Department;
    - 3) Telephone the Business Office at Wyman Park to provide initial application data; send written confirmation to follow within ten (10) days of the phone conversation.

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NOTE: Phone applications will not be retained after the tenth day if written confirmation has not been received.

4. Third Party Billing Collection Staff
  - a. Refer patients (guarantors) to the Financial Counseling Department only after:
    - 1) All Third Party Coverage for services rendered has been exhausted; and/or,
    - 2) An interview with the patient verified an inability to liquidate the Self-Pay balance, using the following guidelines:
      - a) Balance = \$50.00 or less, full payment due in sixty (60) days.
      - b) Balance = \$50.00 to \$350.00, full payment due in ninety (90) days.
      - c) Balance = \$351.00 or more, full payment due in one hundred and eighty (180) days.
  
5. Director, Patient Financial Services, or Designee
  - a. Review all applications for Sliding Fee Financial Assistance. (Complete within 24 hours of receipt of all confirmation data.)
    - 1) Approve/disapprove all applications for balances less than \$2,500.
    - 2) Route any applications for balances equal to or greater than \$2,500 to the Vice President, Finance/CFO for approval.
  - b. Enter the Sliding Fee Financial Status Class with the applicable adjustment percentage into the billing system upon approval. (Adjustments apply to all services received within the approval period -- between the effective date and the termination date.)
  - c. Send out the Notification letter giving patient the Determination of the Financial Assistance Application.
  - d. Adjust the Sliding Fee Scale on annual basis to reflect changes to the "poverty level" income scale.
  
6. Vice President, Finance/CFO or Chief Executive Officer
  - a. Review and approve all Sliding Scale Financial Assistance applications for balances equal to or greater than \$2,500.
  - b. Return all completed determinations to the Director, Business Office, for further processing.

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**APPENDIX A  
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES**

1. \*\*\*Notice of the availability of the JHCP Financial Assistance Program will be posted at patient registration sites within each facility and presented to patients upon request.
2. Each person requesting Financial Assistance must complete a JHM Financial Assistance application.
3. Proof of income must be provided with the application. Acceptable proofs include:
  - (a) Prior year tax return;
  - (b) Current pay stubs;
  - (c) Letter from employer; and
  - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
4. An individual will be eligible for Financial Assistance if the maximum family (husband and wife) income level does not exceed each affiliates standard related to the Federal poverty guidelines, and they do not own liquid assets which would be available to satisfy their JHHS affiliate bills.
5. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.
6. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary private room accommodations. 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.
7. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days (or their specifically established timeline) of satisfactory completion and return of the application. The Manager or designated responsible party will issue the final eligibility determination.
8. Documentation of the final eligibility determination will be made on all (open-balance) patients' account. A determination notice will be sent to the patient.
9. A determination of eligibility for Financial Assistance will remain valid for a period of three (3) months for all necessary JHM affiliate services provided based on the initial date of the determination letter. For recurring outpatient therapeutic services (such as chemotherapy or radiation therapy), patients may qualify for Financial Assistance for up to six (6) months on the basis of a single application. Patients will not be required to reapply for Financial Assistance if they are currently receiving Financial Assistance from another affiliate.
10. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

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## APPENDIX B CATASTROPHIC FINANCIAL ASSISTANCE GUIDELINES

### Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a JHHS Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the JHM affiliate medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 18 months or less.


### General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
  - Medical Assistance
  - The JHM Financial Assistance Program.
  - Other forms of assistance available through JHM affiliates.
3. The patient cannot repay the self-responsible portion of the JHHS affiliate account in 18 months or less.
4. The affiliate has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the non-charitable amount is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a JHHS Catastrophic Assistance Application and non-duplicated supporting documentation.

### Factors for Consideration

The following factors will be considered in evaluating a Catastrophic Assistance Application:

- Current Medical Debt
- Liquid Assets (leaving a residual of \$2,500)
- Living Expenses
- Projected Medical Expenses
- Annual Income
- Spell of Illness
- Supporting Documentation

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### Definitions


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.
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.)
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.
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.

### Exceptions

1. Each affiliate has the right to refuse treatment for elective procedures, which may result in catastrophic medical debt.
2. The Director of Patient Financial Services (or affiliate equivalent) may make exceptions, as circumstances deem necessary.

### Evaluation Method and Process

1. The Financial Counselor will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Catastrophic Assistance Worksheet (see below) 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.

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**Note:** If the below worksheet is electronically available to preparer, double-click on worksheet and fill in required amounts in highlighted fields only. The worksheet will automatically compute rest of the fields.

### FINANCIAL ASSISTANCE WORKSHEET

Patient Name: \_\_\_\_\_  
 History #: \_\_\_\_\_

LINE #	PARTICULAR	AMOUNT
<b>Net Current Medical Debt:</b>		
1	Current Medical Debt	\$ -
2	Total Liquid Assets	\$ -
3	Asset Exclusion (Fixed Amount)	\$ 2,500
4	Net Liquid Assets [If Line 2 > Line 3, then Line 2 - Line 3, otherwise amount is zero "0"]	\$ -
5	Net Current Medical Debt [Line 1 - Line 4]	\$ -

<b>Total Annual Expenses:</b>		
6	Living Expenses	\$ -
7	Projected Medical Expenses	\$ -
8	Total Annual Expenses [Line 6 + Line 7]	\$ -

<b>Annual Income Available:</b>		
9	Income (Net Take Home Pay)	\$ -
10	% Income Available [100% - (Line 8 divided by Line 9 x 100)] [If Line 8 is > Line 9, then % Income Available is zero "0"]	-%
11	Annual Income Available [Line 9 x Line 10]	\$ -

### SELECT PATIENT PAYMENT PERIOD PLAN

<b>Patient Payment in 1-Year Period Plan:</b>		
12	Income Available in 1 Year [Line 11]	\$ -
13	Income Available in 1 Year plus Net Liquid Assets [Line 12 + Line 4]	\$ -
14	Monthly Patient Installment Payment within 1 Year [Line 13 / 12 Months]	\$ -
15	<b>Financial Assistance Amount</b> [If Line 1 > Line 13, then Line 1 - Line 13. This is the Financial Assistance Amount] [If Line 1 < Line 13, then the Financial Assistance Amount is zero "0"]	\$ -

<b>Patient Payment in 2-Year Period Plan:</b>		
16	Income Available in 2 Years [Line 11 x 2 Years]	\$ -
17	Income Available in 2 Years plus Net Liquid Assets [Line 16 + Line 4]	\$ -
18	Monthly Patient Installment Payment within 2 Years [Line 17 / 24 Months]	\$ -
19	<b>Financial Assistance Amount</b> [If Line 1 > Line 17, then Line 1 - Line 17. This is the Financial Assistance Amount] [If Line 1 < Line 17, then the Financial Assistance Amount is zero "0"]	\$ -

<b>Patient Payment in 3-Year Period Plan:</b>		
20	Income Available in 3 Years [Line 11 x 3 Years]	\$ -
21	Income Available in 3 Years plus Net Liquid Assets [Line 20 + Line 4]	\$ -
22	Monthly Patient Installment Payment within 3 Years [Line 21 / 36 Months]	\$ -
23	<b>Financial Assistance Amount</b> [If Line 1 > Line 21, then Line 1 - Line 21. This is the Financial Assistance Amount] [If Line 1 < Line 21, then the Financial Assistance Amount is zero "0"]	\$ -



**The Johns Hopkins Health System  
Policy & Procedure**

*Subject*

**FINANCIAL ASSISTANCE**

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**TABLE FOR DETERMINATION OF  
FINANCIAL ASSISTANCE ALLOWANCES**

**Effective 2/1/08**

# of Persons in Family	Poverty Income Level	Upper Limits of Income for Allowance Range				
		80%	70%	50%	40%	20%
1	<b>\$ 10,400</b>	\$ 12,480	\$ 14,560	\$ 16,640	\$ 18,720	\$ 20,800
2	<b>\$ 14,000</b>	\$ 16,800	\$ 19,600	\$ 22,400	\$ 25,200	\$ 28,000
3	<b>\$ 17,600</b>	\$ 21,120	\$ 24,640	\$ 28,160	\$ 31,680	\$ 35,200
4	<b>\$ 21,200</b>	\$ 25,440	\$ 29,680	\$ 33,920	\$ 38,160	\$ 42,400
5	<b>\$ 24,800</b>	\$ 29,760	\$ 34,720	\$ 39,680	\$ 44,640	\$ 49,600
6	<b>\$ 28,400</b>	\$ 34,080	\$ 39,760	\$ 45,440	\$ 51,120	\$ 56,800
7	<b>\$ 32,000</b>	\$ 38,400	\$ 44,800	\$ 51,200	\$ 57,600	\$ 64,000
8*	<b>\$ 35,600</b>	\$ 42,720	\$ 49,840	\$ 56,960	\$ 64,080	\$ 71,200
Allowance to Give:	\$5 payment	80%	70%	50%	40%	20%

EXAMPLE: Annual Family Income \$36,000  
 # of Persons in Family 4  
 Applicable Poverty Income Level \$21,200  
 Upper Limits of Income for Allowance Range \$42,400 (20% range)  
 \$36,000 is less than the upper limit of income; therefore patient is eligible for financial assistance.

\*For family units with more than eight (8) members, add \$3,600 for each additional member.

Exhibit A

**JOHNS HOPKINS MEDICINE**  
**Financial Assistance Application**

**Patient Name** : \_\_\_\_\_ **Date:** \_\_\_\_\_

**ID Number** : \_\_\_\_\_

**Ref. Accounts** : \_\_\_\_\_

**Dear** \_\_\_\_\_ :

**You or a family member has requested a reduction on your bills related to care provided by The Johns Hopkins Medical Institution and its affiliates. We would like to assist you with your request by conducting a reasonable financial assessment based on your current financial status. Please note that financial assistance cannot be considered for any type of elective medical services. Non-residents of Maryland will only be considered based on special circumstances. We cannot guarantee that your financial status will justify a reduction on balances owed, but we will make every effort to work with you in trying to resolve your accounts.**

**In order to expedite your request, we will need you to provide us with all information no later than 20 days from receipt of this letter. If for any reason this cannot be completed within this timeframe, please contact \_\_\_\_\_ at (410) \_\_\_\_\_ to communicate your concerns.**

**Please complete the form that follows and return it along with the documentation indicated below:**

- 1. Copy of last year's tax returns. (If married and filing separately, please provide copies of both returns.)*
- 2. Copy of the determination letter from Medical Assistance and/or Social Security.*
- 3. Proof of monthly living expenses as recorded on this form.*
- 4. Copies of other medical expenses.*
- 5. Provide copies of last three (3) pay stubs.*
- 6. Copy of Social Security award letter, birth certificate and any/all insurance cards.*

Patient Name: \_\_\_\_\_ S.S. # \_\_\_\_\_

Spouse Name (if any): \_\_\_\_\_ S.S. # \_\_\_\_\_

Home Address (Street, City, State, Zip): \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Alternate Contact Number: \_\_\_\_\_

Number of Dependents: \_\_\_\_\_ Name & Ages: \_\_\_\_\_

Living Arrangements:  Own,  Rent,  Other (Explain Below)

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you receive financial support from a family member (or from any other source)? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

**Monthly Expenses:**

Rent/Mortgage: \$ \_\_\_\_\_

Food: \$ \_\_\_\_\_

Utilities: \$ \_\_\_\_\_

Heat: \$ \_\_\_\_\_

Phone: \$ \_\_\_\_\_

Auto/Transportation: \$ \_\_\_\_\_

Other Expenses for Dependents \$ \_\_\_\_\_

Other Medical/Pharmaceutical, etc.\$ \_\_\_\_\_

**Total Monthly Expenses: \$ \_\_\_\_\_**

**Monthly Income:**

Patient (Self): \$ \_\_\_\_\_

Spouse: \$ \_\_\_\_\_

Other Income: \$ \_\_\_\_\_

**Total Income: \$ \_\_\_\_\_**

**Savings** :Y/N \_\_\_\_\_ Amount: \$ \_\_\_\_\_

**Checking** :Y/N \_\_\_\_\_ Amount: \$ \_\_\_\_\_

**Comments:** \_\_\_\_\_