

# THE HOLY CROSS HOSPITAL FINANCIAL ASSISTANCE Program

Holy Cross Hospital is committed to being the most trusted provider of health care services in our community. That involves a commitment to provide accessible services to individuals who do not have either the personal resources to pay for necessary care or eligibility to qualify for programs that would provide coverage (Medicaid, M-CHIP, MHIP, etc.). The hospital also has a responsibility to paying patients to ensure that patients who are eligible for programs obtain coverage and that those who can pay for their services do pay.

In the event that no public program applies, Holy Cross Hospital has a financial assistance program that will enable any qualifying patient to obtain necessary hospital services. All **Maryland residents** or *patients who present with an urgent, emergent, or life threatening condition*, may apply for financial assistance. **Eligibility is determined on an individual basis, taking into account household income and assets.** Once granted, the eligibility applies to medically necessary services not covered by other programs for a period of six months unless the patient becomes eligible for coverage under public programs during this time.

**APPLIES TO** medically necessary patient services that are rendered at facilities owned and operated solely by Holy Cross Hospital.

**COVERS** all medically necessary services provided and billed by the hospital and the following hospital-based physicians:

Capital Internal Medicine (Hospitalists)	Maternal Fetal Associates
Community Neonatal Associates	Pathology Associates of Silver Spring
Diagnostic Medical Imaging Associates	Silver Spring Emergency Physicians
Holy Cross Anesthesiology Associates	Sunrise Medical Group (Intensivists)

**DOES NOT COVER**

- Services rendered by physicians and other health care providers not listed above
- Services that are not medically necessary (cosmetic, convenience, elective surgical procedures)
- Services to patients who qualify for county, state, federal, or other assistance programs

**SPECIAL APPLICATIONS** and financial assistance provisions apply to care received at Holy Cross Hospital Health Centers, Adult Day Care, and for current participants of Montgomery Cares, Maternity Partnership, Project Access or Care for Kids.

Please contact the Financial Counseling Office at (301) 754-7195 for more information.

**For more information**, ask about Holy Cross Hospital's financial assistance policy when you register for inpatient or outpatient services, call **(301) 754-7195** or visit:

[http://www.holycrosshealth.org/patients\\_financial.htm](http://www.holycrosshealth.org/patients_financial.htm)

**Did You Remember To:**

- Fill out the application completely and sign your name in the final box?
- Enclose copies of supporting documentation for each income and asset amount listed?

Financial Assistance may only be granted based on the receipt of a **complete and signed** Financial Assistance Application along with the following documentation requirements: (*Provide Copies Only*)

Note that the income levels listed in the table below are the initial qualifier for a two-part test that also involves income and net assets. Anyone with income in excess of \$75,000 is not eligible for scheduled financial assistance. Individuals with net assets in excess of \$10,000 or families with net assets in excess of \$25,000 are not eligible for scheduled financial assistance.

**Required Documentation:**

**1. Patient’s Photo Identification**

**2. Proof of Residency: Must show one of the following as proof of Maryland residency (unless patient presents with an urgent, emergent, or life-threatening condition):**

- Driver’s license with current address
- Maryland state ID card
- Voter registration card
- Recent pay stub with name and address
- Mortgage or lease bill
- Property tax bill
- Utility bill with complete name and address
- Current tax return / W2

Schedule of Financial Assistance			
# of Household Members	Level of Financial Assistance Available		
	100%	60%	30%
1	\$21,780	\$27,225	\$32,670
2	\$29,420	\$36,775	\$44,130
3	\$37,060	\$46,325	\$55,590
4	\$44,700	\$55,875	\$67,050
5	\$52,340	\$65,425	\$75,000
6	\$59,980	\$75,000	\$75,000
7	\$67,620	\$75,000	\$75,000
8	\$75,000	\$75,000	\$75,000
9	\$75,000	\$75,000	\$75,000
10	\$75,000	\$75,000	\$75,000

Rev 02/04/2011

**3. Please provide documentation as proof of each reported income/asset for all income and asset sources listed within this application. Acceptable forms of documentation are:**

**INCOME**

- Most recent paystubs for one month period
- Employer letter confirming income amount
- Unemployment letter from state
- Cash assistance letter from state and Food Stamps
- Housing Assistance Letter (HOC)
- Court letter stating income
- W2 from most recent tax filing
- Most recent tax return
- Self employment earnings (Schedule C from taxes)
- Schedule E from taxes
- SSA/SSI award letter
- Support letter stating assistance to patient
- Alimony letter and or Child Support

**ASSETS**

- Bank statement(s) – checking and/or savings
- Mortgage statement
- Stocks statement
- Bonds statement
- CD statement
- Money market statement
- Reverse mortgage benefits statement
- Vehicles – proof of ownership

\*If a family member (spouse, etc.) or someone other than a family member is providing you more than 50 percent support for living expenses, please provide the above documentation for the supporting individual.

**Household Income** is defined as the income of all individuals who live together and typically purchase and prepare meals together.

**Questions About Documentation?** Please contact our Financial Counseling office at (301) 754-7195 or visit us at [http://www.holycrosshealth.org/patients\\_financial.htm](http://www.holycrosshealth.org/patients_financial.htm)



**I. Household Income:** Defined as income of all individuals who live together and typically purchase and prepare meals together.

List the amount of your monthly income from all sources. If a family member or someone other than a family member provides more than 50 percent support for living expenses, please provide monthly income for the supporting individual. Please provide a copy of documentation to support each income and asset source listed.

<b>Monthly Amount</b>	<b>Patient</b>	<b>Spouse</b>	<b>Other</b>
Employment .....	\$ _____	\$ _____	\$ _____
Retirement/pension benefits .....	\$ _____	\$ _____	\$ _____
Social security benefits (SSA/SSI) .....	\$ _____	\$ _____	\$ _____
Public assistance benefits (food stamps, HOC) .....	\$ _____	\$ _____	\$ _____
Disability benefits .....	\$ _____	\$ _____	\$ _____
Unemployment benefits .....	\$ _____	\$ _____	\$ _____
Alimony .....	\$ _____	\$ _____	\$ _____
Child support.....	\$ _____	\$ _____	\$ _____
Rental property income (Does anyone pay you rent?)	\$ _____	\$ _____	\$ _____
Self employment .....	\$ _____	\$ _____	\$ _____
Other income source .....	\$ _____	\$ _____	\$ _____
<b>Total Monthly Gross Income:</b>	\$ _____	\$ _____	\$ _____

**For Hospital Use Only**  
TOTAL INCOME \_\_\_\_\_

If you entered any amounts into the "Other" column above, describe that individual's relationship to the patient:

**II. Assets:**

	<b>Patient</b>	<b>Spouse</b>	<b>Other</b>
Checking account.....	\$ _____	\$ _____	\$ _____
Savings account .....	\$ _____	\$ _____	\$ _____
Stocks, bonds, CD, or money market.....	\$ _____	\$ _____	\$ _____
Other accounts .....	\$ _____	\$ _____	\$ _____
<b>Total Assets:</b>	\$ _____	\$ _____	\$ _____

If you entered any amounts into the "Other" column above, describe that individual's relationship to patient:

Home / mortgage loan outstanding balance	\$ _____	Approximate value \$ _____
Second home / other property loan outstanding balance	\$ _____	Approximate value \$ _____
Vehicle #1 ..... Make _____ Year _____		Approximate value \$ _____
Vehicle #2..... Make _____ Year _____		Approximate value \$ _____
Vehicle #3..... Make _____ Year _____		Approximate value \$ _____

**For Hospital Use Only**  
TOTAL ASSETS \_\_\_\_\_

I/we hereby certify under the penalties of perjury that the information contained herein is true, correct, and complete. I understand that you will retain this application electronically whether or not it is approved, and that financial assistance will not be granted if complete and accurate information and supporting documentation are not provided. Any assistance granted will be rescinded if information given on the application is inaccurate or untrue. You are authorized to verify income and asset information as well as employment history through a public credit-reporting agency. I understand that I am responsible for payment of any remaining percentage of my outstanding balance in order for the financial assistance granted to me by Holy Cross Hospital to become effective.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ (Patient)

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ (Spouse/Guarantor)

If you or your organization would like to make a contribution supporting the provision of health care services to those in need, please contact the Holy Cross Hospital Foundation at (301) 754-7130. You may mail your contribution to Holy Cross-Hospital Foundation, 11801 Tech Road, Silver Spring, MD 20904