Holy Cross Hospital
Financial Counseling
1500 Forest Glen Road
Silver Spring, MD 20910-1484
Phone: (301) 754-7195
Fax: (301) 754-3227

Holy Cross Germantown Hospital
Financial Counseling
19801 Observation Drive
Germantown, MD 20876
Phone: (301) 557-6195
Fax: (301) 557-5549

THE HOLY CROSS HEALTH FINANCIAL ASSISTANCE PROGRAM

Holy Cross Health 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, CHIP, etc.).

In the event that no public program applies, Holy Cross Health 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, considering household income and assets.** Once granted, the eligibility applies to medically necessary services provided at the hospital, which are not covered by other programs for a period of six months unless the patient becomes eligible for coverage under public programs during this time. Coverage periods may vary depending on the Financial Assistance program for which the patient may qualify.

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

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

- Capital Internal Medicine (Hospitalists)
- Maternal Fetal Associates
- Community Neonatal Assoc.
- Pathology Assoc. of Silver Spring
- Diagnostic Medical Imaging Assoc.
- Silver Spring Emergency Physicians
- Holy Cross Anesthesiology Assoc.
- 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
- ❑ Services rendered at private physician offices and other facilities
- ❑ Services rendered by Home Health Care and Hospice Care Services
- ❑ Services rendered at the Adult Day Care Center

COVERAGE IS AVAILABLE FOR PARTICIPANTS OF MARYLAND STATE AND MEANS-TESTED SOCIAL SERVICES PROGRAMS:

- ❑ Montgomery Cares, Project Access, or Care for Kids Programs.
- ❑ Household with Children in the Free or Reduced Lunch, Food Stamps or Supplemental Nutritional Assistance, Maryland Low-income-household Energy Assistance and Women, Infant and Children Programs.

MEDICAL FINANCIAL HARDSHIP ASSISTANCE:

- ❑ If you have Holy Cross Health debt greater than 25% of your family income (*not including co-insurance, co-payments, hospital-based physician bills, and/or deductibles*) please inquire on how to apply.

For more information, regarding our Financial Assistance Program, please call our financial counselors at 301-754-7195 for Holy Cross Hospital or 301-557-6195 at Holy Cross Germantown Hospital.

Form Rev 04/17/2024

Holy Cross Hospital Financial Assistance Application

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Account/Reference # ____________

Financial Assistance Program
Patient Profile Questionnaire

Please <u>complete</u> this Questionnaire fully and return it with your <u>complete and signed</u> Financial Assistance Application.

Patient Name: ____ **Date of Birth:** ____________
First Middle Last

Question	Answer	Office Use Only
1) What is the patient's age on date of service?	________	
2) Does the patient have health insurance?	Yes or No	
If Yes, what is the name of the health insurance company?	________	
3) Is the patient a U.S. Citizen or permanent resident (*for Medicaid determination*)?	Yes or No	MA
4) If Permanent resident (how many years)?	________	
5) Is patient pregnant?	Yes or No	
6) Are any of your children under 21 years of age living at home with you?	Yes or No	
7) Is patient blind or is patient potentially disabled for 12 months or more from gainful employment	Yes or No	
8) Is the patient currently receiving Social Security Administration benefits (**SSA**)?	Yes or No	
9) Is the patient currently receiving Supplemental Security Income – (**SSI**/**SSDI**)?	Yes or No	
10) Is patient a resident of the State of Maryland?	Yes or No	
If not a Maryland resident, in what state does patient reside?	________	
11) Are you a patient at a Holy Cross Health Center?	Yes or No	
If Yes, which Health Center? ….❑ Gaithersburg ….❑ Silver Spring ….❑Aspen Hill ….❑ Germantown		
12) Is patient homeless?	Yes or No	
13) Is the patient employed?	Yes or No	
If No, date became unemployed?	________	
14) Has patient applied for unemployment?	Yes or No	
If Yes, start date of benefits?	________	
15) Does the patient, guarantor/spouse participate with or currently have the following Maryland State and Means-Tested Social Services Programs? **Note: Please provide a copy of the award letter or enrollment card in order to expedite your request:**		
a. Women, Infant and Children Program (**WIC**)	Yes or No	MC
b. Household with Children in the Free or Reduced Lunch (**NSLP**)	Yes or No	MD
c. Maryland Low-Income-Household Energy Assistance (**MEAP**)	Yes or No	ME
d. Food Stamps or Supplemental Nutrition Assistance Program (**SNAP**)	Yes or No	MF
e. Primary Adult Care Program (**PAC**)	Yes or No	MG
f. Montgomery Cares	Yes or No	E7
g. Project Access	Yes or No	MH
h. Care for Kids	Yes or No	MI

Office Use Only Received By: ____________________
Forwarded To: ______________________ Date:__________

Account/Reference#________________________________

Holy Cross Hospital Financial Assistance Application

Please complete/answer every section on this form, indicate "N/A" if not applicable

Section 1

Information About You *(Patient):*

Name: ____ Date of Birth: ____________

First *Middle* *Last*

Social Security Number: _____ - _____ - ______ Marital Status: ☐ Single ☐ Married ☐ Separated

Home Address: ____

City State Zip Code

Employer Name: ____

Employer Address: ____

City State Zip Code

Cell/Home Phone: _________________________ Work Phone: ______________________________

(Area Code) ### - #### *(Area Code) ### - ####*

Household Members *(Spouse/Children/Dependents):*

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

Note: If you applied for Medicaid and have not received a final determination, please contact your DHHS case worker to determine your eligibility. The Financial Assistance Application will be processed once a final determination is received.

Have you applied for Maryland Medical Assistance ☐ Yes ☐ No If yes, what was the date you applied? ___________

If yes, what was the determination? (eligible, not eligible, other, disabled, etc.)? ________________________

Have you applied for insurance through the Health Exchange? ☐ Yes ☐ No

Were you approved for an insurance plan through the Health Exchange? ☐ Yes ☐ No

Have you enrolled for an insurance plan through the Health Exchange? ☐ Yes ☐ No

Do you have any other unpaid Holy Cross Health medical bills? ☐ Yes ☐ No

If so for what Holy Cross Health service? ____

If you have arranged a payment plan, what is the monthly payment? ______________________________

Did you file your Federal & State Income Taxes? ☐ Yes ☐ No If yes, for what year? ________________

Section 2

Supporter/Guarantor Information *(Parent/Spouse/Life Partner/Significant Other):* *indicate "N/A" (not applicable)*

Name:____

First Middle Last

☐ Spouse ☐ Parent ☐ Other (indicate relationship to Patient) ______________________________

Social Security Number: ______-____-______ Marital Status: ☐ Single ☐ Married ☐ Separated

Maryland Resident: ☐ Yes ☐ No

Guarantor's Date of Birth: _______________

Home Address: ____

City State Zip Code

Cell/Home Phone: ____________________ Employer Name: ____________________Work Phone: ___________________

Did you file your Federal & State Income Taxes? ☐ Yes ☐ No If yes, for what year? ________________

***** Please complete/answer every section on this form, indicate N/A if not applicable or Zero (0) if not applicable*****

Section 3

I. Household Income: *Defined as income of all individuals who live together: patient, spouse; biological, adopted, or step-children; anyone for whom patient claims a personal exemption in a state or federal tax return.*
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** (*see page 5 and 6*).

Monthly Amount	**Patient**	**Parent/Spouse Life Partner/Significant Other**	**Other**
Employment	$__________	$__________	$__________
Retirement/pension benefits	$__________	$__________	$__________
Social security benefits (SSA/SSI)	$__________	$__________	$__________
Public assistance benefits (Food Stamps/HOC)	$__________	$__________	$__________
Disability benefits	$__________	$__________	$__________
Unemployment benefits	$__________	$__________	$__________
Veterans/Military benefits	$__________	$__________	$__________
Alimony	$__________	$__________	$__________
Child support	$__________	$__________	$__________
Rental property income (Does anyone pay you rent?)	$__________	$__________	$__________
Self-employment	$__________	$__________	$__________
Other income source	$__________	$__________	$__________
Total Monthly Gross Income:	**$**__________	**$**__________	**$**__________

II. Assets:	**Patient**	**Parent/Spouse Life Partner/Significant Other**	**Other**
Checking account	$__________	$__________	$__________
Savings account	$__________	$__________	$__________
Stocks, bonds, CD, or money market	$__________	$__________	$__________
Other accounts	$__________	$__________	$__________
Total Assets:	**$**__________	**$**__________	**$**__________

III. Other Assets:

Home / mortgage loan outstanding balance………………$_____________ Approximate value $_______________

Vehicle #1 .... Make ___________ Year ________ Approximate value $_______________

Vehicle #2 .... Make ___________ Year ________ Approximate value $_______________

Vehicle #3…………………….. Make ___________ Year ________ Approximate value $_______________

Other Property……………….... _________________________________ Approximate value $_______________

Total Other Assets: _______________

IV. Monthly Expenses:	**Amount**		**Amount**
Rent or Mortgage	$____________	Car Insurance	____________
Utilities	$____________	Health Insurance	____________
Car Payment(s)	$____________	Other Medical Expenses	____________
Credit Card(s)	____________	Other Expenses	____________

Section 4

I/we hereby certify under the penalties of perjury that the information contained herein is true, correct, and complete. I understand that Holy Cross Health 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. Holy Cross Health is 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 Health to become effective.

Date: ______________ **Signature:**____ (Patient)

Date: ______________ **Signature:**____ (Parent/Spouse/Life Partner/Significant Other)

Date: ______________ **Signature:**____ (Other)

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 Health Foundation at (301) 754-7130. You may mail your contribution to the Holy Cross-Health Foundation, 10720 Columbia Pike, Silver Spring, MD 20901.

Holy Cross Hospital Financial Assistance Application

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).

- **Identification Requirements:**

❑ Copy of Patient's Photo Identification
❑ Copy of Proof of Maryland Residency

- **Maryland Means-Tested Social Services Programs:**
Please provide the award letter or the enrollment card:

❑ Women, Infant and Children Programs (**WIC**)
❑ Household with Children in the Free or Reduced Lunch Program (**NSLP**)
❑ Low-Income-Household Energy Assistance Program (**MEAP**)
❑ Food Stamps or Supplement Nutrition Assistance Program (**SNAP**)
❑ Montgomery Cares
❑ Project Access
❑ Care for Kids

- If you do not participate in any of the above programs, please provide the **following documents: (Copies Only)**

❑ Copy of Last Year Taxes – All Pages
❑ Copy of Recent Pay Stubs – **Current Full Month**
❑ If you are self-employed, please provide a letter explaining your monthly/yearly gross income. Letter must include; date, name, address, phone number, explanation and signature(s)
❑ Letter from employer confirming your total monthly or annual income. Letter must include the following: date, name, address, phone number, explanation and signature(s)
❑ Copy of Bank Statements (Checking/Savings – all pages) – **Current 2 months**
❑ If you are self-employed or providing letter from employer, please provide (Checking/Savings – all pages) **Current 3 months**
❑ Copy of recent Mortgage Statement or Deed if paid-off
❑ If you do not have open accounts or have not had previous services at Holy Cross Health, **please provide a copy of the physician referral or order** with the completed Financial Assistance Application.

❑ ____

❑ ____

- If you do not work and are being supported by a family member (spouse, etc.) or someone other than a family member, please provide the above documentation for the supporting individual(s).

For additional information regarding the required documents and or questions, please contact the Financial Counseling Department at 301-754-7195 for Holy Cross Hospital or 301-557-6195 at Holy Cross Germantown Hospital.

HOLY CROSS HEALTH
A Member of Trinity Health

Holy Cross Hospital Financial Assistance Application

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

Note: General Financial Assistance is based on a two-part test that involves an income and net assets. Individuals with net assets in excess of $10,000 or families with net assets in excess of $25,000 are not eligible for Financial Assistance.

Step 1) Verification of Identification (*1 document required*) - **Copy Only**							
❑	Driver's License	❑	Maryland State ID Card	❑	CASA ID	❑	Passport
Step 2) Verification of Maryland Residency (*1 document required*) Unless patient presents with an urgent, emergent, or life threatening condition - **Copy Only**							
❑	Recent Paystub with Name and Address	❑	Voter Registration Card	❑	Utility Bill with Complete Name and Address	❑	Property Tax Bill
❑	Mortgage or Lease Statement	❑	Current Tax Return / W2				
Step 3) Verification of Maryland Means-Tested Social Services Programs – Provide award letter or copy of enrollment card **Copies Only**							
❑	Women, Infant and Children Program (WIC)	❑	Household with Children in the Free or Reduced Lunch Program (NSLP)	❑	Low-Income Energy Assistance Program (MEAP)	❑	Food Stamps or Supplemental Nutritional Assistance Program (SNAP)
❑	Project Access	❑	Montgomery Cares	❑	Care for Kids	❑	
Approval is based on submission of proof of enrollment (Active Beneficiary of one of the programs) within 30 days of application submission. If proof is not submitted within 30 days of application, the general Financial Assistance guidelines will be followed (Income/Assets).							
Step 4) Verification of income – Provide documentation to support each income amount listed on application: **Copies Only** **Note:** *We may require more than 1 document to confirm income*							
❑	Pay Stubs: Last Month: (*4 – Weekly, 2 – Biweekly, 1 – Monthly*)	❑	Unemployment Benefits Award Letter	❑	Social Security Disability Insurance – (SSDI)	❑	VA/Military Benefits
❑	Alimony Letter and or Child Support **	❑	Cash Assistance Award Letter	❑	Housing Opportunity Commission (HOC) – Award Letter	❑	Employer Letter Confirming Patient's Monthly Income Amount**
❑	Supplemental Security Income (SSI) Award Letter	❑	Social Security Administration (SSA) Award Letter	❑	Supporters Letter Stating Assistance To Patient **		
❑	Recent Tax Return – All pages: *(Last Year) Including but not limited to Self Employment Earnings (Schedule C from Tax Return), Schedule E from Taxes (Rental Schedule)*						
Step 5) Verification of Assets – Provide documentation to support each asset amount listed on application: Copies Only **Note:** *We may require more than 1 document to confirm assets*							
❑	Checking Account (Official Statement) *Current 2 and/or 3 months*	❑	Savings Account (Official Statement) *Current 2 and/or 3 months*	❑	Mortgage Statement and/or Deed	❑	Bonds/Stocks Statement
	Reverse Mortgage Benefit Statement	❑	Certificate of Deposit (CD) Statement	❑	Money Market Statement		

* 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 individuals.

If you do not have open accounts or have not had previous services at Holy Cross Health, please provide a copy of the physician referral or order with the completed application.

Important: *Documents marked with an ** must include the date, name, address and telephone number, detailed explanation and signature(s) of the person(s) making the statement.*

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

For more information, regarding our Financial Assistance Program, please call our financial counselors at 301-754-7195 for Holy Cross Hospital or 301-557-6195 at Holy Cross Germantown Hospital.