Mercy
HEALTH SERVICES

PATIENT INFORMATION:
BILLING AND FINANCIAL ASSISTANCE POLICY

Overview of MMC's Financial Assistance Policy: Mercy Medical Center (MMC) provides and promotes health services for the people of Baltimore of every creed, race, economic, and social condition. In the spirit of its sponsor, the Sisters of Mercy, MMC has a special commitment to the underserved and the uninsured.

MMC renders emergency care to all patients without regard to their ability to pay for such services. MMC also accepts, within the limits of its financial resources, all patients who require non-emergency hospital services, without regard to their ability to pay for such services. These policies, however, do not preclude MMC from reviewing:

a. The patient's ability to pay;
b. The availability of insurance benefits; or
c. The patient's eligibility for Medical Assistance.

Services will be provided at no charge or at a reduced charge (based on a sliding scale) to patients who are unable to pay based on incomes up to approximately 400% above the federal poverty guidelines. (These guidelines are issued each year by the U.S. Department of Health and Human Services). MMC's financial assistance program is more generous than that required by Maryland law. Please see MMC's full Financial Assistance Policy for eligibility requirements and other information.

Patient's Rights and Obligations: MMC encourages patients to seek information and / or assistance related to their financial obligations to MMC. Each patient's circumstance is unique, but all patients have similar rights and obligations:

- Patients may request a financial assistance application at any point in the billing and collection process
- Patients may apply for Medical Assistance through MMC or directly with the Department of Health and Mental Hygiene. MMC offers an on-site State case worker to assist.
- Patients should contact the MMC billing office with any questions related to their bill, collection activities or to request a copy of MMC's Financial Assistance Policy.
- Patients are responsible for satisfying their financial obligations.
- Patients are responsible for providing timely, accurate information which is needed to verify insurance coverage or to determine eligibility for financial assistance, if they seek such assistance.

Contact Information: If you have any questions regarding an MMC bill, your financial obligations, or want more information about MMC's Financial Assistance Policy or Maryland's Medical Assistance program, you are encouraged to use the following contact information:

• MMC Billing Inquiries / Statements	(410) 951-1700
• MMC Financial Assistance Application	(410) 951-1700 www.hscrc.state.md.us/consumers_uniform.cfm
• MMC Financial Counseling	(410) 332-9273
• MMC / Maryland Medical Assistance	(410) 332-9396 or 9273
• Maryland Medical Assistance	(800) 332-6347 or TTY (800) 925-4434 www.dhr.state.md.us

Please Note: Physician Services are NOT included in the Hospital bill.
Physician services are billed SEPARATELY

Update: 6/1/09

Maryland State Uniform Financial Assistance Application

Information About You

Name: _____
First *Middle Initial* *Last*

Social Security Number [ ] - [ ] - [ ] Marital Status: ☐ Single ☐ Married ☐ Separated

US Citizen: ☐ Yes ☐ No Permanent Resident: ☐ Yes ☐ No

Home Address: _____
Street Address
_____
City *State* *Zip code* *Country*

Home Phone: ( ) -
(Area Code) ### - ####

Employer Name & Address: _____
Employer Name
_____
Street Address
_____
City *State* *Zip code*

Work Phone: ( ) -
(Area Code) ### - ####

Household Members:

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

Have you applied for Medical Assistance ☐ Yes ☐ No

If yes, what was the date you applied? [ ]/[ ]/[ ] *(MM/DD/YYYY)*

If yes, what was the determination?

Do you receive any type of state or county assistance? ☐ Yes ☐ No

Hospital Name
Return Address

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	
Retirement/pension benefits	
Social security benefits	
Public assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self employment	
Other income source:	
Total	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total	

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home : Loan Balance: _____ Approximate value: _____

Automobile: Make: _____ Year: _____ Approximate value: _____

Additional vehicle: Make : _____ Year: _____ Approximate value: _____

Additional vehicle: Make: _____ Year: _____ Approximate value: _____

Other property: _____ Approximate value: _____

Total _____

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car payment(s)	
Credit card(s)	
Car insurance	
Health insurance	
Other medical expenses	
Other expenses	
Total	

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

For what service? _____

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

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____

Applicant signature *Date* *Relationship to Patient*