2023

Financial

Assistance

Application

Atlantic General Hospital

ATTN: Financial Assistance, Box # 66

9733 Healthway Drive

Berlin, MD 21811-1155

410-629-6025 Office

410-641-9515 Fax

www.atlanticgeneral.org

Financial Assistance Summary

Plain Language Summary

Patient's Obligations and Rights regarding Hospital bills

For patients with the ability to pay, it is their obligation to pay their bill in a timely manner. If they fail to meet this obligation, they may be referred to a collection agency. If a patient believes they have been wrongly referred to a collection agency, they have the right to contact the hospital for more information at 410-641-9101. If a patient is uninsured or underinsured, financial assistance (FA) may be available. There are certain criteria that must be met in order to qualify for FA. If a patient applies for FA, it is their responsibility to provide all required information and supporting documents to the hospital so that their eligibility can be determined. Partial or full financial assistance will be granted based on the patient's ability to pay the billed charges. The information below summarizes Atlantic General Hospital's Financial Assistance Policy. For more information regarding FA, please call 410-629-6025 or visit the AGH website: http://www.atlanticgeneral.org/fap

Overview

It is the policy of Atlantic General Hospital/Health System to provide medically necessary services without charge or at a reduced cost to all eligible persons, who are unable to pay, according to the Hospital's guidelines. Atlantic General Hospital defines all emergency room care as medically necessary even though decisions by insurance companies may be in conflict with this decision.

A FA eligible individual may not be charged more than the Amounts Generally Billed (AGB) for emergency or other medically necessary care. Eligibility for financial assistance is based on several factors, including income (see Federal Poverty Level guidelines below), household size, assets and any special consideration that the patient would like to have considered.

Patients may be eligible for Medical Assistance or other public assistance. Patients can apply at their local Department of Social Services or online. Information and applications are available at the following state websites: **https://health.maryland.gov (MD), https://dhss.delaware.gov/dhss/dss/medast.html (DE), https://www.dmas.virginia.gov/for-applicants (VA).** Maryland residents might be able to apply for assistance with MD Children's Health Program if the assistance is for a child or a pregnant woman. Patients may also apply for Qualified Medicare Beneficiary (QMB) or Specified Low Income Medicare (SLMB) programs if they need assistance with Medicare premiums.

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement.

Am I eligible?

AGH bases Financial Assistance on the patient's income level falling within these ranges:

- 0% to 200% of the Federal Poverty Guideline - 100% reduction for Medically Necessary care
- Between 201% and 225% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 75%
- Between 226% and 250% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%
- Between 251% and 300% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

An application is deemed eligible for 100% Financial Assistance if a patient is enrolled in a means tested program such as:

- Reduced/free school lunches
- SNAP (food stamps)
- MEAP (energy assistance)
- WIC

There are other circumstances where Financial Assistance may automatically apply. Please contact 410-629-6025 for more information.

How can I apply?

The uniform financial assistance application can be found online at: http://www.atlanticgeneral.org/fap. This application can also be obtained at any Atlantic General Hospital Registration area (9733 Healthway Drive, Berlin, MD 21811) or the Patient Accounting Office (10026 Old Ocean City Blvd, Unit 6, Berlin, Maryland 21811). This form, the FA application and FA policy are available upon request and free of charge. These forms are also available in Spanish and Large Print.

If you would like to file a complaint against Atlantic General Hospital for an alleged violation of its financial assistance policy, contact the Health Services Cost Review Commission at hscrc.patient-complaints@maryland.gov.

Atlantic General Hospital

Financial Assistance Program

INCOME GUIDELINES

Effective 01-19-2023

Table 1

Income Scale for AGH Financial Assistance based on Federal Poverty Guidelines

Financial Assistance (FA) %		100%	75%	50%	25%
Persons in Family / Household	2023 Federal Poverty Guidelines	Income Multiple			
		Up to 200%	201% up to 225%	226% up to 250%	251% - 300%
1	$14,580	$29,160	$32,805	$36,450	$43,740
2	$19,720	$39,440	$44,370	$49,300	$59,160
3	$24,860	$49,720	$55,935	$62,150	$74,580
4	$30,000	$60,000	$67,500	$75,000	$90,000
5	$35,140	$70,280	$79,065	$87,850	$105,420
6	$40,280	$80,560	$90,630	$100,700	$120,840
7	$45,420	$90,840	$102,195	$113,550	$136,260
8	$50,560	$101,120	$113,760	$126,400	$151,680
For families/households with more than 8 persons, add $5,140 for each additional person					

Table 2

Income Scale for AGH Medical Hardship Assistance based on Federal Poverty Guidelines

Financial Assistance (FA) %		100%	75%	50%	25%
Persons in Family / Household	2023 Federal Poverty Guidelines	Income Multiple			
		Up to 200%	300%	400%	500%
1	$14,580	$29,160	$43,740	$58,320	$72,900
2	$19,720	$39,440	$59,160	$78,880	$98,600
3	$24,860	$49,720	$74,580	$99,440	$124,300
4	$30,000	$60,000	$90,000	$120,000	$150,000
5	$35,140	$70,280	$105,420	$140,560	$175,700
6	$40,280	$80,560	$120,840	$161,120	$201,400
7	$45,420	$90,840	$136,260	$181,680	$227,100
8	$50,560	$101,120	$151,680	$202,240	$252,800
For families/households with more than 8 persons, add $4,720 for each additional person					

** Atlantic General Hospital's Medical Hardship provision applies to patients whose household income is between 0% - 500% of the Federal Poverty Guidelines. Medical Hardship is defined when the household's total Atlantic General Hospital bills exceed 25% of the household's annual family income. If the patient qualifies under both Table 1 and Table 2, the more favorable amount of financial assistance will be provided.*

FINANCIAL ASSISTANCE PROGRAM – INFORMATION SHEET

Eligibility: A patient must have a valid social security number, visa, or green card, and meet the income guidelines. Patients must apply within 240 days from the first patient responsible bill received. If a patient appears eligible for State Medical Assistance, then he/she must apply and get the results before we can finalize his/her financial assistance application.

Determination: The financial assistance program is based on family size per the patient's federal tax return (1040), and the entire household's ***gross*** income for the past twelve (12) months. A patient and his/her claimed dependents are automatically approved for 100% financial assistance for medically necessary services, if the patient or a dependent show proof of a means tested program.

Check-List: Please return the below items as soon as possible.

OPTION # 1 Provide proof of a means tested program:

Type of Form	Notes
Proof of Means Tested Programs	Food stamps, Maryland Energy Assistance, WIC, SLMB, free or reduced school lunches, housing assistance, or Senior Prescription Drug Assistance Program.

OPTION # 2 Provide all of the following financial information:

Type of Form	Notes
Federal Tax Return (Form 1040)	Most recently filed Federal Tax Return (Form 1040); we do not need your state tax return.
Proof of All Income for Everyone listed on the 1040 form	Last four (4) paystubs, and proof of social security, disability, pension, retirement, annuities, year-to-date unemployment, etc. If self-employed, provide a year-to-date profit and loss report.
Bank Statements	Statements for the last three (3) months of each account (checking, savings, money market, IRA, etc.)

IMPORTANT NOTE: We may request additional information at any time during the application process.

Submission: The application and supporting documents can be mailed to the address below. It can also be faxed to 410-641-9210, or dropped off at Atlantic General Hospital - Emergency Room Main Entrance, ATTN: Financial Assistance, Box # 66.

Atlantic General Hospital
ATTN: Financial Assistance, Box # 66
9733 Healthway Drive
Berlin, MD 21811

Last Steps: Once the financial assistance application and supporting documentation has been processed, a letter with the results will be mailed to the patient. Please note, if supporting documentation is missing the application will be placed on hold. Patients have three (3) weeks from the date the application is received to submit all remaining and necessary documents.

Regardless of financial assistance, patients are responsible for calling the number on the back of each bill received, to discuss options.

If you have any questions about the financial assistance program, please call our Financial Counselor at 410-629-6025.

Atlantic General Hospital's financial assistance program is not insurance. It covers bills from Atlantic General Hospital, Atlantic General Health System (doctors, surgeons, hospitalists, anestheologists, that are employed by AGH), and Atlantic General Hospital Corporation for medically necessary services. It does not include bills from other providers such as Emergency Service Associates, Delmarva Radiology, Peninsula Pathology, Delmarva Heart, etc. The patient must call these companies and inquire about their assistance programs.

FOR OFFICE USE ONLY – DATE REC'D: _____

Maryland State Uniform Financial Assistance Application

Information About You

Patient's Name: _____
First *Middle* *Last*

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

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

Home Address: _____ Home Phone:
Street Address

_____ ( ) -
City *State* *Zip Code* *Country* *(Area Code) ### - ####*

Employer: _____
Employer Name

_____ Work Phone:
Street Address

_____ ( ) -
City *State* *Zip Code* *Country* *(Area Code) ### - ####*

Household Members:

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/YY)

If yes, what was the determination? _____

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

Please return the completed application and required documents to:

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Berlin, MD 21811

If you have any questions about the financial assistance program,
please call our Financial Counselor at **(410) 629-6025.**

I. Family Income

List the amount of your **gross** 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 10 days of the change.

_____

Applicant Signature *Date* *Relationship to Patient*