FINANCIAL ASSISTANCE

BrightView is dedicated to servicing the health care needs of its patients.
To assist in meeting those needs, we have established this "Financial Assistance Policy"
to provide financial relief to those patients who first meet the requirements as described
in this policy.

BrightView is committed to providing medically necessary healthcare services to patients regardless of their insurance status or ability to pay. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients qualifying for assistance under this policy will receive a discount for services rendered.

BrightView offers financial assistance to patients seeking treatment whose income is at or under a percentage of the publicly available Federal Poverty Guidelines. To qualify for financial assistance from BrightView, the patient must:

- Cooperate with Case Manager and Financial Counselor efforts to apply and qualify for Medicaid
- Be deemed ineligible for Medicaid or other governmental programs
- Submit application for financial assistance and all accompanying documentation

Proof of income

As part of the application, at least one of the items in the following list of documentation is required for proof of income. If more than one is applicable, all should be submitted.

a. If you claim that you have no income, a sworn statement from the individual providing you basic support is required.
b. Three consecutive months of pay stubs, or all pay stubs within past three months if not employed for three months.
c. Copy of previous year's federal tax return.
d. Social Security, Unemployment, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.

Some individuals may not have income able to be documented as indicated above but have significant assets available to pay for healthcare services. In these situations, BrightView may require documented proof of assets for evaluation and approval of the application.

Application Processing

Upon receipt of the required documentation, the application will be processed by the Revenue Cycle team and resulting discounts will be applied to outstanding patient balances. The patient or guarantor is responsible for the remaining balance after discounts. The Revenue Cycle team will attempt to notify the patient of discounts, but no guarantees are made of notification, outside of the reflection of discounts on future statements or requests for payment.

Eligibility Criteria

Eligibility for discount will be based upon income for the family, as a percentage of Federal Poverty Guidelines. The qualification for discounts is listed in the table below and may be updated in accordance with updates to the Federal Poverty Guidelines.

For families/households with more than 8 persons, add $4,480 for each additional person.				
	100% discount	**100% discount**	**85% discount**	**50% discount**
Family Size	Under FPL	100% - 200% FPL	200% - 300% FPL	300% - 400% FPL
1	$12,760	$25,520	$38,280	$51,040
2	$17,240	$34,480	$51,720	$68,960
3	$21,720	$43,440	$65,160	$86,880
4	$26,200	$52,400	$78,600	$104,800
5	$30,680	$61,360	$92,040	$122,720
6	$35,160	$70,320	$105,480	$140,640
7	$39,640	$79,280	$118,920	$158,560
8	$44,120	$88,240	$132,360	$176,480

Approval Duration

Approval for Financial Assistance will be for six-month time periods. After six months, an updated application will be required.

RESOURCES

- **Maryland Medicaid Administration**: 1-855-642-8572 https://www.marylandhealthconnection.gov/

- **Maryland Department of Labor-Division of Unemployment Insurance:** 1-667-207-6520, https://www.dllr.state.md.us/employment/unemployment.shtml

- **Maryland Department of Human Services-Child, Family and Adult Services:** 1-800-332-6347, https://dhs.maryland.gov/

BrightView

Date Received by Site:	
Primary Site:	
MRN:	
Date Received by FCT:	

FINANCIAL ASSISTANCE APPLICATION

Today's Date: _____

Patient's Name: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

1. This application must be completed in its entirety to be considered for financial assistance.
2. Please list all family members (including yourself). Family members include the applicant, spouse, children (natural or adoptive) under the age of 18 in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security/Pension benefits, alimony, public assistance, self-employment, etc. Income also includes rent or living expenses that are being provided for you.

Family Member	Age	Relationship to Patient	Income Source	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.		Self			
2.					
3.					
4.					
5.					
6.					

Send proof of three months of gross income with this application:

Gross income is total income before taxes are taken out, and includes but is not limited to:

- Three consecutive months of pay stubs or all pay stubs within the last three months if not employed for three months.
- Copy of previous year's federal tax return.
- Social security, unemployment, alimony, child support, workers compensation award letter, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.
- Any other income statements.

3. If you reported zero total income, how are you being supported?

_____

_____

Please have the following support statement completed by the person(s) helping to support you and/or your family.

FINANCIAL ASSISTANCE APPLICATION

Support Statement

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being supported financially. List services, if any, that you are receiving for providing this support.

_____

_____

_____

_____

I certify that all of the above information provided is true and correct to the best of my knowledge. My signature does not obligate me to provide financial support related to the medical service of the applicant.

_____ _____

Signature of person providing financial support to applicant Address of responsible party

_____

City, State Zip Code

4. Have you applied for Medicaid or any other county assistance?

_____ No _____ Yes (Date/State _____)

5. Did you have health insurance on the date of service?

_____ No _____ Yes (Provide a copy of your card)

By signing this document, I affirm the answers on this application are true. Should further review of an individual's financial assistance application reveal that information provided was either incorrect of fraudulent, the decision to provide assistance may be reversed and the responsible party will be billed.

Patient Signature: _____ Date: _____

Applicant or Representative Signature: _____

Relationship: _____ Date: _____

Mail completed application and documentation to:

BrightView
P.O. Box 639886
Cincinnati, Ohio 45263-9886