MAIMONIDES MEDICAL CENTER

CODE: FIN-028 (Revised)
DATE: March, 2026
ORIGINALLY ISSUED: March 21, 2005

SUBJECT: FINANCIAL ASSISTANCE POLICY

I. POLICY

Maimonides Medical Center (MMC) strives to provide high quality health care services to every patient who comes to one of our facilities, regardless of ability to pay. This Financial Assistance Policy ("FAP" or "Policy") implements Maimonides' financial assistance program, through which patients who lack insurance coverage, are underinsured, have high deductible health plans (HDHP) and would be required to cover a substantial portion of the costs themselves, and/or have exhausted their health insurance benefits, and are deemed eligible for financial assistance in compliance with this Policy may access free or discounted emergency and other medically necessary care.

II. SCOPE

This policy applies to Maimonides Medical Center, Bay Ridge Emergency Department, Faculty Practices and Article 28 sites ("Maimonides Medical Center").

III. DEFINITIONS

Amount Generally Billed (AGB)- the maximum amount a hospital will charge a patient eligible for financial assistance based on what is paid to them by Medicare and private insurers.

Child Health Plus (CHP)- offers comprehensive health insurance for uninsured children who are not eligible for Medicaid.

Federal Poverty Level (FPL)- A set of income thresholds used by the U.S. government to determine eligibility for various federal assistance policies

Financial Assistance Policy (FAP)- A written document outlining how a healthcare provider, often a hospital, offers free or discounted services to patients who cannot afford to pay for their medical care.

High Deductible Health Plans (HDHP)- A type of health insurance plan with deductible amounts, meaning the policy holder must pay a significant amount out of pocket before the insurance starts covering medical expenses.

Limited English Proficiency (LEP)- refers to individuals who do not speak English as their primary language and have a limited ability to read, speak, write or understand English.

Medicaid Application Processing System (**MAPS**)- a software designed to streamline the Financial Assistance Process. Medicaid/Financial Assistance applications are submitted and tracked through MAPS.

IV. PROCEDURE

A. Access to information

Maimonides Medical Center makes this Policy, the Universal Financial Assistance Application, and a summary of the FAP ("Plain Language Summary") available on a designated Financial Assistance page on MMC's website (https://maimo.org/patients-visitors/paying-for-care/). Paper copies of these documents are available upon request and without charge, by mail and at the Patient Financial Services Department.

MMC notifies and informs patients about the FAP by: 1.offering a paper copy of the Plain Language Summary as part of intake and registration; 2.including notification on the discharge summary; 3.including a written notice on billing statements that informs recipients about availability of financial assistance under the FAP and includes the telephone number of the MMC's Financial Services Department and the direct web site address where copies of the FAP, FAP application form and Plain Language Summary can be obtained; 4.and conspicuous public displays that inform patients about the FAP in public locations in the Hospital, including the Emergency Room and admission areas. Patients will be informed of Maimonides' FAP by multi-lingual signage.

In addition, the FAP, FAP application form and Plain Language Summary will be translated into the primary languages spoken by populations with Limited English Proficiency ("LEP") serviced by the Hospital each year, including the language spoken by each LEP language group that constitutes the lesser of 1,000 Individuals or 5 percent of the community served by the Hospital or the population likely to be affected or encountered by the Hospital. The Financial Assistance Application and signage for registration areas includes a QR code that will direct the patients to MAPS (Medicaid Application Processing System), where the patient can self-screen and provide documentation through a secure portal. The portal also provides the contact information for Financial Services.

Patients with specific inquiries about financial assistance will be provided with the Plain Language Summary, informed of the related information on the Maimonides Medical Center website, and referred to a Financial Counselor.

Where an individual indicates that he/she prefers to access documents or information about the FAP electronically, MMC may provide such documents or information electronically (including on an electronic screen, by email or by providing the direct website address or URL, of the web page where the document or information is posted).

B. Financial Assistance Eligibility

Individuals that meet the following criteria are eligible for free or discounted care under this Policy:

- For medically necessary non-emergency services, low-income residents of the five boroughs of New York City (Kings, New York, Queens, Richmond and Bronx counties) who are uninsured, have HDHP and would be required to cover a substantial portion of the costs themselves, and/or who have exhausted their health insurance benefits are eligible for financial assistance.

- For emergency services, low-income residents of New York State who are uninsured or who have exhausted their health insurance benefits are eligible, as well as patients with HDHP who would be expected to pay a substantial portion of the costs themselves.

The maximum charge that may be billed to a patient who receives emergency or other medically necessary care at **the Hospital**, and is eligible for financial assistance under this FAP is the AGB. Maimonides sets the AGB at the total amount Medicaid would allow (for inpatient care) and the total amount that Medicare would allow (for outpatient ambulatory surgery, clinic, emergency department, referred ambulatory and ancillary services).

Pursuant to the discount fee schedules described in Attachments A and B, discounts offered to FAP-eligible patients under the FAP are less than or equal to the AGB. Following determination of FAP-eligibility, a FAP-eligible individual may not be charged more than the AGB for medically necessary or emergency care.

Financial criteria for eligibility and discounts under the FAP are described further below and in Attachments A and B. **Patients with incomes below 400% of the Federal Poverty level are presumptively eligible for assistance under the FAP, based on information described in Section III.D, below.** An additional condition of eligibility is that patients (and for patients who are minors, their parent/s and/or legal guardian/s) provide the necessary documentation for the financial assistance application, and otherwise cooperate fully with the staff helping them in the process.

To the extent that patients are eligible for a publicly sponsored insurance program (e.g., Medicaid, CHP, Prenatal Care Assistance Program), patients must utilize that program for coverage of their treatment rather than the Maimonides' financial assistance program. Patients seeking financial assistance (and for patients who are minors, their parent/s and/or legal guardian/s) must provide all information and documentation requested to determine eligibility for a publicly sponsored insurance program to the Financial Services Department. Once a patient has applied for coverage under a publicly sponsored insurance program, he or she will be eligible for financial assistance from MMC up to the date on which the patient is deemed to be covered by the other program, as long as he or she is otherwise eligible for financial assistance.

- In addition to covering the uninsured who may qualify, this policy covers those individuals who qualify and face extraordinary medical costs, including copayments, deductibles, or coinsurance, and/or who have exhausted their health insurance benefits (including, but not limited to, health savings accounts).

Underinsured patients earning up to 400% FPL are eligible to apply for financial assistance. Underinsured is defined as patients whose paid medical expenses have exceeded 10% of their gross income in the last 12 months. MMC will not initiate legal action against any patient whose income is at or below 400% of the Federal Poverty Level.

Immigration status cannot be used to determine eligibility under the FAP.

Financial assistance may be made available, as determined on a case-by-case basis, for patients who do not meet the financial eligibility criteria but face extraordinary medical costs. Requests for financial assistance in these circumstances will be directed to the Financial Services Department at 983-48th Street, Brooklyn, NY 11219, (718) 283-7790.

Patients with HMO/commercial insurance that is not accepted at MMC are not eligible for financial assistance, unless the patient has exhausted their insurance benefits.

Patients will be ineligible for financial assistance if the Financial Services Department determines that false information was provided by the patient (or for patients who are minors, their parent/s and/or legal guardian/s) during the application process.

C. Covered/Non-Covered Services

MMC's financial assistance program covers emergency and other medically necessary services at Maimonides Medical Center. Medicare guidelines are used to determine whether services are medically necessary. Ancillary services ordered in connection with clinic visits will be charged at the sliding scale percentage rate that corresponds to that clinic visit.

The following are not covered under this Policy:

i. Items that are not medically necessary (e.g., cosmetic procedures);
ii. Items without clinical or therapeutic benefit (e.g., telephones, televisions and private room differential charges);
iii. Services not billed by MMC (e.g., anesthesia services and professional services by non-participating physicians and independent contractors, such as private duty nurses, home care services, and ambulette services), other than services provided by substantially related entities of the Hospital, as such term is defined under federal regulations

Patients who qualified for emergency Medicaid as inpatients at MMC are eligible for one post-operative clinic visit without charge and any related ancillary services within 90 days of the surgery, and are not required to complete the documentation request to be eligible for that visit. However, patients should be referred to Financial Services as further follow-up may be required.

Patients who are seen in the Emergency Room but who are not admitted as inpatients are eligible for one follow-up clinic visit without charge for the specific condition which brought them to the Emergency Room, and are not required to complete the

documentation requests to be eligible for that visit. However, patients should be referred to Financial Services as further follow-up may be required.

Outpatient mental health services are covered under FIN-29 Outpatient Mental Health Services Financial Assistance Policy, and not under this Policy. Inpatient mental health services and related ancillary services are covered under this Policy.

D. General Application Procedures

In order to obtain assistance with the FAP application process, apply for financial assistance under, or obtain additional information about the FAP, an individual may contact MMC's Financial Services Department at (718) 283-7790, located at 983-48th Street, Brooklyn, NY 11219.

Each individual requesting financial assistance will be referred to a Financial Counselor for screening. The Financial Counselor will:

1. Discuss various alternatives available to the patient (e.g., publicly sponsored insurance programs, payment arrangements, discounted rates, sliding scales, free care) based on the information received.

2. In appropriate circumstances, (a) complete a Medicaid application and submit it on behalf of the patient; or (b) refer the patient to the appropriate local Medicaid office to complete a CHP application.

3. If appropriate, provide a financial assistance application for the applicant to complete. Upon request, the Financial Counselor will provide assistance to patients on understanding the financial assistance policies and complete the application on their behalf during a face-to-face interview.

FAP application forms will be translated, in accordance with Section IV, above. In addition, translation services will be available to all patients needing such services to access financial assistance at the Hospital. Staff will access translation services in accordance with AD-120 Translation and Interpreter Services.

The application forms will include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility under this Policy, the patient may disregard any bills until the Hospital has rendered a decision on the application.

Patients are permitted to apply for financial assistance at any point, including during the collections process. (See FIN-55, Billing and Collections Policy for more information about application periods). Requests to waive these requirements may be directed to the Director of Financial Services for review.

E. Eligibility Criteria for Financial Assistance

1. Eligibility Determination Procedures

Consideration for Financial Assistance Program includes a review of the responsible party's annual household income, number of people in the home, existing debt and other indicators of party's ability to pay. Eligibility for financial assistance is based solely on household income. Patient assets are not considered in any eligibility determination. These are guidelines, and each individual situation will be reviewed independently and shall not take into account age, gender, race, color, national origin, religion, social or immigrant status, sexual orientation, gender identity, spousal affiliation, physical handicap, or mental handicap. The Vice President of Revenue Cycle may grant approval if there was extenuating circumstances.

Determinations of eligibility will be made by the Financial Services Department. Eligibility shall be based on the following information:

- Place of Residence;
- Annual, pre-tax income;
- Family size.

Information provided in the patient's application will be used to obtain this data. If no such application has been made or is available, the necessary information for determinations of financial assistance eligibility must be provided by the patient. If any required information is missing, patients will be advised by phone or mail of the missing information.

2. Income

Attachment A to this Policy, "Sliding Scale Fee Discount Schedule for Inpatient Services," sets forth the discounts for covered inpatient services. Attachment B, "Sliding Fee Scale Discount Table for Ambulatory Surgery, Clinic, Emergency Department, Referred Ambulatory and Ancillary Services," sets forth the discounts for covered outpatient, clinic, emergency, ambulatory, and ancillary services.

Each Attachment sets forth an Income Test:

- The *Income Test* is calculated by comparing the patient's "family size" with his or her family's annual, pre-tax income.

- Family Size. If the patient is an adult, the patient's family size is calculated by adding the patient, the patient's spouse (if any and if he/she resides with the patient) and any dependents of the patient or the patient's spouse. If the patient is a child, the patient's family size is calculated by adding the patient, the patient's parent/s and/or legal guardian/s with which the patient resides, and any dependents of the patient's parent/s and/or legal guardians with which the patient resides (other than the patient). A pregnant woman is counted as two family members.

- Annual Pre-Tax Income. If the patient is an adult, the family's annual pre-tax income is the sum of the patient's and the patient's spouse's (if any and if he/she resides with the patient) income. If the patient is a minor, the family's annual pre-

tax income is the income of the patient's parent/s and/or legal guardian/s with which the patient resides. Income is based on the calculation of last four weeks earnings prior to the date of service.

- Annual, pre-tax income will be the total of the following sources of income, as evidenced by the documentation required on the FAP application:

    1. Salary/Wages Before Deductions.
    2. Social Security Benefits.
    3. Unemployment & Workmen's Compensation.
    4. Veteran's Benefit.
    5. Alimony/Child Support.
    6. Other Monetary Support
    7. Pension Payments.
    8. Insurance or Annuity Payments.
    9. Dividends/Interest.
    10. Rental Income.
    11. Net Business Income (self-employed/verified by independent source).
    12. Other (strike benefits, training stipends, military family allotments, income from estates and trusts).

    Source of income should be calculated by adding amounts actually received, as opposed to those amounts that the individual may be entitled to but are not being paid to him or her (e.g., when the ex- spouse of a patient fails to pay child support, insurance or pension payments are in dispute).

F. Process for Review of Applications

Within 30 days of receipt of the completed application for financial assistance and all required documents, the Financial Services Department will notify the patient in writing whether the application for financial assistance has been approved or declined. If the application has been approved, the patient will be informed of the percentage discount (e.g., 90% of applicable fees) for which he or she is eligible and given a detailed explanation of amounts owed. If the application has been denied, the written notice shall describe how to appeal the denial and include information on how to contact the Department of Health. FAP-denial notifications must also detail the basis for the denial. In cases where a face- t o - f a c e interview is conducted; the patients are informed immediately of approval of the application and the amount of discount the patient will receive or of denial of the application. In such cases the written notice is also mailed to the patient's home.

In addition, if the patient is approved for financial assistance, the Financial Services Department will document the determination of eligibility in the "comments" section of the registration system (AHS), including the specific applicable discounts for (a) inpatient services and (b) outpatient services, even if only one type of service (e.g., inpatient services) is required in the current care of the patient.

Approval of eligibility is valid for one year, at which point recalculation of eligibility will

be necessary. Future changes to the established sliding scales set forth in Attachments A and B shall apply to all new and currently qualified patients.

G. Installment Payment Arrangement

Upon request, patients receiving financial assistance will be given an opportunity to obtain an installment payment arrangement interest free. The monthly payment will not be greater than 5% of the patient's gross monthly income. No interest will be charged on the unpaid balance even in the event a payment is missed. In the event of a missed payment, there will be no acceleration of payments.

H. Appeals

A patient has the right to appeal a decision on eligibility for financial assistance based on the following criteria:

i. Incorrect information was provided;
ii. Changes in patient financial status occurred; or
iii. Extenuating circumstances.

The Director of Financial Services will decide appeals. Appeals must be made in writing (or in person, by appointment) to the Director of Financial Services at the following address:

983- 48th Street
Brooklyn, NY 11219
Telephone: (718) 283-7790

The appeal must be made within 30 days of notification of the eligibility determination. The Director of Financial Services will strive to make appeal decisions within 10 business days of receipt of a patient appeal (i.e., after receipt of a letter or an in-person appeal).

I. Separate Billing and Collections Policy

The actions that Maimonides may take in the event of non-payment are described in FIN-55 Billing and Collections Policy. This policy is available on a designated Financial Assistance page on Maimonides' website (https://maimo.org/patients-visitors/paying-for-care / Paper copies of this policy are available upon request and without charge, by mail and at Patient Financial Services, 983 48th St. Brooklyn NY 11219

J. Access to Emergency Medical Care

MMC will not deny emergency or medically necessary services to any patient on the basis of an outstanding balance or prior failure to pay. There will be no discrimination in the provision of a medical screening examination and necessary stabilizing treatment against those eligible for financial assistance under this policy or for those with an unpaid medical bill. Maimonides provides, without discrimination, care for emergency medical conditions to individuals, regardless of whether they are eligible for financial assistance under this FAP. See FIN-034 EMTALA - Medical Screening Examination and

Stabilization Policy.

K. Training and Further Information

All staff who interact with patients or have responsibility for billing and collections will receive a copy of this Policy and will be trained on the appropriate procedure for the financial assistance program. Staff will also be periodically informed of additional discounts or funding that may be available through special grants or programs separate from the general financial assistance program. Any further inquiries by staff on this Policy should be directed to the Manager of the Financial Counseling Unit at (718) 283-7796.

Employees of Maimonides and their dependents will be treated per established Medical Center Policy (FIN-022).

V. CONTROLS

The Director of Finance (Financial Services) and Senior Vice President of Revenue Cycle, will periodically review patient master records and accounts for adherence to the Financial Assistance protocol set in this Policy.

The Director of Finance (Financial Services) and Patient Accounts will direct the appropriate Department Heads to revise the Financial Assistance protocol set forth in this Policy as changes are approved or mandated by regulatory agencies.

The Office of Corporate Compliance shall evaluate compliance with the Financial Assistance Law and this policy at least annually.

INDEX: Charity Care, Self-Pay, Financial Assistance

REFERENCES:
PHL 2807-k (9 and 9-a)
Dear Administrator letter dated February 15, 2007 Patient Protection and Affordable Care Act §9007(a) (March 23, 2010) (Adding 501(r) to IRC);
FIN-034 EMTALA - Medical Screening Examination and Stabilization Policy
FIN-029 - Outpatient Mental Health Services Financial Assistance Policy
FIN-055 - Billing and Collections Policy
Dear Administrator Letter dated November 15, 2013 Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule, 79 Fed. Reg. 78954 (Dec. 31, 2014).
26 C.F.R. 1.501(r)-1, 1.501(r)-4 - 1.501(r)-6

DEPARTMENT RESPONSIBLE: Financial Services

ATTACHMENTS:

Attachment A: Sliding Scale Fee Discount Table for Inpatient Services
Attachment B: Sliding Scale Fee Discount Table for Outpatient and Clinic Services

Attachment A

Sliding Scale Fee Discount Schedule for Inpatient Services

MAIMONIDES MEDICAL CENTER

2026 SLIDING SCALE FEE DISCOUNT SCHEDULE FOR INPATIENT SERVICES BASED ON MEDICAID RATES

Attachment A

Test A - Income Test[1]

Family Size	Federal Poverty Guidelines LEVEL 1	Income Range II 1.25	LEVEL	Income Range III 1.5	LEVEL	Income Range IV 2.0	LEVEL	Income Range V 2.5	LEVEL	Income Range VI 3.0	LEVEL	Income Range LEVEL VII 4.0	
1	$15,960	$15,961	$19,950	$19,951	$23,940	$23,941	$31,920	$31,921	$39,900	$39,901	$47,880	$47,881	$63,840
2	$21,640	$21,641	$27,050	$27,051	$32,460	$32,461	$43,280	$43,281	$54,100	$54,101	$64,920	$64,921	$86,560
3	$27,320	$27,321	$34,150	$34,151	$40,980	$40,981	$54,640	$54,641	$68,300	$68,301	$81,960	$81,961	$109,280
4	$33,000	$33,001	$41,250	$41,251	$49,500	$49,501	$66,000	$66,001	$82,500	$82,501	$99,000	$99,001	$132,000
5	$38,680	$38,681	$48,350	$48,351	$58,020	$58,021	$77,360	$77,361	$96,700	$96,701	$116,040	$116,041	$154,720
6	$44,360	$44,361	$55,450	$55,451	$66,540	$66,541	$88,720	$88,721	$110,900	$110,901	$133,080	$133,081	$177,440
7	$50,040	$50,041	$62,550	$62,551	$75,060	$75,061	$100,080	$100,081	$125,100	$125,101	$150,120	$150,121	$200,160
8	$55,720	$55,721	$69,650	$69,651	$83,580	$83,581	$111,440	$111,441	$139,300	$139,301	$167,160	$167,161	$222,880
9	$61,400	$61,401	$76,750	$76,751	$92,100	$92,101	$122,800	$122,801	$153,500	$153,501	$184,200	$184,201	$245,600
10	$67,080	$67,081	$83,850	$83,851	$100,620	$100,621	$134,160	$134,161	$167,700	$167,701	$201,240	$201,241	$268,320
For each Addt'l person add	$5,680	$7,100		$8,520		$11,360		$14,200		$17,040		$22,720	
Discount amount based on Medicaid DRG	100%	90%		80%		70%		60%		50%		40%	
Percentage Over FPL	100% of FPL	101% to 125% of FPL		126% to 150% of FPL		151% to 200% of FPL		201% to 250% of FPL		251% to 300% of FPL		301% to 400% of FPL	

Full Medicaid Rates are due from patients whose income exceeds 400% of the FPL

Attachment B

Sliding Fee Scale Discount Table for Ambulatory Surgery, Clinic, Emergency Department, Referred Ambulatory and Ancillary Services

CODE: FIN-28
DATE: 2026

MAIMONIDES MEDICAL CENTER

2026 SLIDING FEE SCALE DISCOUNT SCHEDULE FOR OUTPATIENT AMBULATORY SURGERY, CLINIC, ER DEPT., REFERRED AMBULATORY AND ANCILLARY SERVICES BASED ON MEDICARE APC RATES

Attachment B

Test A - Income Test[1]

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Family Size	Federal Poverty Guidelines LEVEL 1	Income Range II 1.25	LEVEL	Income Range III 1.5	LEVEL	Income Range IV 2.0	LEVEL	Income Range V 2.5	LEVEL	Income Range VI 3.0	LEVEL	Income Range VII 4.0	LEVEL	Income Range LEVEL VIII	Asset Test Minimum Resource Level
1	$15,960	$15,961	$19,951	$19,952	$23,940	$23,941	$31,920	$31,921	$39,900	$39,901	$47,880	$47,881	$63,840	$63,841 Amt Above	
2	$21,640	$21,641	$27,051	$27,052	$32,460	$32,461	$43,280	$43,281	$54,100	$54,101	$64,920	$64,921	$86,560	$86,561 "	
3	$27,320	$27,321	$34,151	$34,152	$40,980	$40,981	$54,640	$54,641	$68,300	$68,301	$81,960	$81,961	$109,280	$109,281 "	
4	$33,000	$33,001	$41,251	$41,252	$49,500	$49,501	$66,000	$66,001	$82,500	$82,501	$99,000	$99,001	$132,000	$132,001 "	
5	$38,680	$38,681	$48,351	$48,352	$58,020	$58,021	$77,360	$77,361	$96,700	$96,701	$116,040	$116,041	$154,720	$154,721 "	
6	$44,360	$44,361	$55,451	$55,452	$66,540	$66,541	$88,720	$88,721	$110,900	$110,901	$133,080	$133,081	$177,440	$177,441 "	
7	$50,040	$50,041	$62,551	$62,552	$75,060	$75,061	$100,080	$100,081	$125,100	$125,101	$150,120	$150,121	$200,160	$200,161 "	
8	$55,720	$55,721	$69,851	$69,852	$83,580	$83,581	$111,440	$111,441	$139,300	$139,301	$167,160	$167,161	$222,880	$222,881 "	
9	$61,400	$61,401	$76,751	$76,752	$92,100	$92,101	$122,800	$122,801	$153,500	$153,501	$184,200	$184,201	$245,600	$245,601 "	
10	$67,080	$67,081	$83,851	$83,852	$100,620	$100,621	$134,160	$134,161	$167,700	$167,701	$201,240	$201,241	$268,320	$268,321 "	
For each Addt'l person add	$5,680	$7,100		$8,520		$11,360		$14,200		$17,040		$22,720		N/A	
Discount amount based on Medicaid DRG	100%	90%		80%		70%		60%		50%		40%		0%	
Percentage Over FPL	100% of FPL	101% to 125% of FPL		126% to 150% of FPL		151% to 200% of FPL		201% to 250% of FPL		251% to 300% of FPL		301% to 400% of FPL		Over 300% of FPL	

Full APC Medicare Rates are due from patients whose income exceeds 400% of the FPL