

PLAIN LANGUAGE SUMMARY – Financial Assistance Policy and Application

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

In accordance with Centegra’s Mission, Vision and Values, as well as in accordance with applicable state and federal laws, Centegra Hospitals will provide free or discounted care or other public programs to insured and uninsured patients based on financial need. If you are deemed eligible for Financial Assistance, you may not be charged more than the Amount Generally Billed for emergency or medically necessary care and will receive free or significantly discounted care. Please see Centegra’s Financial Assistance Policy for additional information.

ELIGIBILITY: Eligibility is based on family size and household income. There are three types of discounts:

1. Full Financial Assistance discount 100%
2. Partial Financial Assistance discount 80%
3. Partial Financial Assistance discount 70%

Family Size	2019 FPL Guidelines	100% FA Discount 200% FPL	80% FA Discount 350% FPL	70% FA Discount 600% FPL
1	\$12,490	\$24,980	\$43,715	\$74,940
2	\$16,910	\$33,820	\$59,185	\$101,460
3	\$21,330	\$42,660	\$74,655	\$127,980
4	\$25,750	\$51,500	\$90,125	\$154,500
5	\$30,170	\$60,340	\$105,595	\$181,020
6	\$34,590	\$69,180	\$121,065	\$207,540
7	\$39,010	\$78,020	\$136,535	\$234,060
8	\$43,430	\$86,860	\$152,005	\$260,580

For family units of more than 8 people add \$4,420 for each additional person

The FED guidelines are effective January 11th, 2019

HOW TO SECURE YOUR DISCOUNT IMMEDIATELY

1. Complete the brief Financial Assistance Application
2. Provide the following supporting documentation:
 - a. 2 bank statements and proof of any/all income sources for applicant (and spouse if applicable)
 - b. Most recent completed income tax forms and/or most recent W2
 - c. Signed Room and Board form as applicable
 - d. Zero income statement as applicable (for applicant and/or spouse)
 - e. Additional documents may be required upon receipt per the Financial Assistance Policy
3. Return Application and supporting documentation to Centegra in person, by U.S. Mail, email or fax to:

Centegra Health System	Financial Assistance Coordinator
Financial Assistance Coordinator	Phone: 815-334-5578 Fax: 815-334-5039
P.O. Box 1990	527 W. South Street
Woodstock, IL 60098	CentegraFinancialAssistance@centegra.com

WHERE TO OBTAIN A FREE COPY OF THE FINANCIAL ASSISTANCE POLICY AND APPLICATION

1. Online at <https://www.nm.org/patients-and-visitors/billing-and-insurance/financial-assistance>
2. By contacting one of the above Financial Assistance Coordinators in person or by telephone, fax or mail
3. Copies of the Financial Assistance Policy and Application are also available in Spanish. If translations are needed in other languages, please let a Financial Assistance Counselor know.

A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE

However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required, but will help the hospital determine whether you qualify for any public programs.

By completing the application, you, the Patient, acknowledge that you have made a good faith effort to provide all information requested in the application to assist us in determining whether you are eligible for financial assistance.

Once your completed application is processed, a written determination will be mailed to you. Please be aware that Financial Assistance may not be available for ALL services or for ALL providers. Please refer to Exhibit C of the Financial Assistance Policy for further explanation of services and providers covered under the Policy. Financial Assistance will not be approved until any and all applicable third party payments have been received. If you incur additional medical bills, you may be required to reapply with current documents.

FINANCIAL ASSISTANCE APPLICATION

VISIT IS(S): _____

Patient Name: _____ Date of Birth: _____

Guarantor Name: _____ Guarantor Date of Birth: _____

Spouse/Partner Name: _____ Spouse/Partner Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip Code _____

Phone Number: _____ Cell Number: _____ Email Address: _____

PATIENT/GUARANTOR INFORMATION

Social Security Number: _____

Employer: _____

Employer Address: _____

Employer Phone Number: _____

Hire Date: _____ Term Date: _____

SPOUSE/PARTNER INFORMATION

Social Security Number: _____

Employer: _____

Employer Address: _____

Employer Phone Number: _____

Hire Date: _____ Term Date: _____

HEALTH INSURANCE

Does your employer offer Health Insurance benefits? Yes No

Are you eligible for VA benefits? Yes No

Are you eligible for COBRA benefits? Yes No

Health Insurance Carrier: _____ Policy #: _____ Effective Date: _____

Is your balance related to workers compensation or other liability? Yes No If yes, date of accident: _____

DEPENDENTS CLAIMED ON IRS 1040 – INCLUDE NAME, AGE AND RELATIONSHIP

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

MONTHLY INCOME AND ASSETS

	<u>PATIENT</u>	<u>SPOUSE/PARTNER</u>
Wages	_____	_____
Pension	_____	_____
Social Security	_____	_____
Rental Income	_____	_____
Child Support	_____	_____
Alimony	_____	_____
Gov't Assistance	_____	_____
IRA Distributions	_____	_____
401k Distributions	_____	_____
Unemployment	_____	_____
Workers Comp	_____	_____
Other	_____	_____
Totals	_____	_____

ASSETS

	<u>PATIENT</u>	<u>SPOUSE/PARTNER</u>
Savings Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Checking Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stocks/Bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

MONTHLY EXPENSES: PATIENT AND SPOUSE/PARTNER

Housing: Rent or Mortgage:	\$ _____
Utilities:	\$ _____
Food:	\$ _____
Other	\$ _____
Total Expenses:	\$ _____

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient/Guarantor Signature (Required) Date

Financial Counselor Signature Date

FINANCIAL ASSISTANCE
ZERO INCOME STATEMENT / RESIDENTIAL STATEMENT

To be completed by the person applying for Financial Assistance

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Patient Telephone Number: _____

Account Number(s): _____

I hereby state that I am currently unemployed and have no means of income.

I hereby state that I am currently homeless or living in a shelter.

If living in a shelter, please provide the name: _____

To be completed by the Spouse of the person applying for Financial Assistance

Spouse's Name: _____

Spouse's Date of Birth: _____

I hereby state that I am currently unemployed and have no means of income.

I hereby state that I am currently homeless or living in a shelter.

If living in a shelter, please provide the name: _____

Patient's Signature

Date

Spouse's Signature

Date

P.O. Box 1990
Woodstock, IL 60098

ROOM AND BOARD STATEMENT

Required if patient depends on someone else to help meet all or part of daily living expenses. To be completed by the person and/or the patient's family assisting the patient.

Date: _____

Patient Name: _____

Account Number(s): _____

Your Name: _____

Your Address: _____

Your Phone Number: _____

Relationship to Patient: _____

How long have you been providing assistance? _____

Please specify what you provide for the patient:

I have provided:

- Room and/or Board (lodging and food)
- Transportation expenses, car loan, car insurance, gas, etc.
- Medication
- Clothing
- Credit card payments
- School expenses
- Other, please describe: _____

I provide room and board for the above named person but am unable to contribute toward his/her medical expenses.

Signature

Date