Current Status: *Active*	**PolicyStat ID:** *7116367*

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Next Review:	*10/23/2020*
Owner:	*Shannon Hartke: CORP DIR PFS*
Area:	*Patient Intake*
References:	
Applicability:	*Southern Illinois Healthcare Corporate System*

Healthcare Assistance Program and Presumptive, SY-PI-092

Applies to:

Patient Registration

I. POLICY

Consistent with SIH's mission, vision, values and strategic plan, SIH believes that it has a responsibility to meet the financial needs of the patients and the community it serves that has an inability to pay for healthcare services. This policy provides guidance for meeting this responsibility. Southern Illinois Healthcare does not discriminate in the provision of services to an individual based upon the individual's race, color, sex, national origin, disability, religion, age or sexual orientation.

II. DEFINITIONS

ABE: Application of Benefits Eligibility

ABN: Advanced Beneficiary Notices

AGB: amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage

Bill: SIH utilizes date mailers and itemized statements to inform patients of the status of their account; for the purpose of this policy these items are not considered a bill

Civil union: a legal relationship between 2 persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act

Covered services: emergent or medically necessary

ECA: Extraordinary Collection Actions

Federal Poverty Guidelines: the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services

Financial Counselor: SIH employee who assists patients with resolution of their financial responsibility including Health Care Assistance

Financially Indigent: an uninsured or underinsured person who does not have the ability to pay for services rendered

FPL: Federal Poverty Level

HAP ADD-ON Acct: refers to account(s) that are identified while a HAP application is in the review process, the original application has been final approved and accounts were not on the original HAP worksheet

Healthcare Assistance Application: an application which allows for the collection of information for Healthcare Assistance consideration (see examples 1,2,3,4 and 5)

Healthcare Assistance Program (HAP): financial assistance provided to SIH patients who meet Financially Indigent, Medically Indigent or Hospital Uninsured Patient Discount Act criteria

Homeless: individual, who doesn't have a stable, long term place to stay, lacks a fixed, regular and adequate night-time residence or resides in a Homeless Shelter

Hospital Information System: computer related software used to register or scan information received or printed on behalf of a patient

Hospital Uninsured Patient Discount Act: SIH has rural and critical access hospitals that are required to provide discounts for uninsured Illinois residents with family income less than 300% FPL; discount is 100% minus 135% of cost utilizing the ratio of cost to charges from worksheet C, Part I from the most recent filed cost report

Illinois Resident: a person who lives in Illinois and who intends to remain living in Illinois indefinitely

JCHD: Jackson County Health Department

Judicci: a program utilized to search for pertinent information regarding estate claims

Medi: a Medicaid Eligibility system

Medicaid Eligible: a person who is deemed eligible for medical benefits as determined through the state of Illinois Medical Management System and evident by Recipient Identification Number (RIN)

Medically Indigent: refers to a patient whose hospital bill(s), after application of Financially Indigent criteria, exceeds a specified percentage of the patient's annual income and who is not required to pay the remaining balance of their bill(s)

Medical Necessity/Medically Necessary: services provided which are reasonable and necessary

MyChart: Secure online Patient Portal

Party to a civil union: a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act; party to a civil union means, and is included in any definition of use of the terms spouse, family, immediate family, dependent, next of kin, and other terms that denote the spousal relationship

PFS: Patient Financial Services

PFS Representative: SIH employee who works in PFS Department and obtains documentation required for processing Presumptive Eligibility

Presumptive Eligibility: the criterion used to deem a patient eligible for financial assistance based on the guidelines set forth in this policy

Scrutiny: for the purpose of this policy, scrutiny means a completed Healthcare Assistance Application is not

required

SIH: Southern Illinois Healthcare

Sixty (60) days: the number of days a patient will not be billed or account sent to Bad Debt/Collections

Total yearly income: the sum of the yearly gross income

Search America: program utilized to obtain financial assistance screening results which includes a person's family size, propensity to pay score and other financial information which is used to determine presumptive eligibility

Uninsured patient: a patient of a hospital who is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, worker's compensation, accident liability insurance or other third party liability

III. RESPONSIBILITIES

1. All staff is required to follow the guideline established within this policy with regard to the completion and processing of all healthcare assistance procedures.

IV. EQUIPMENT/MATERIALS

1. Hospital Information System

V. PROCEDURE

1. A party to a civil union is entitled to the same legal obligations, responsibilities, protections, and benefits as are afforded or recognized by the law of Illinois to spouses, whether they derive from statute, administrative rule, policy, common law, or any sources of civil or criminal law.
2. Commitment To Provide Emergency Medical Care
    1. SIH provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this HAP policy.
        A. SIH hospitals will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.
        B. Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all SIH patients in a non-discriminatory manner, pursuant to each hospital's respective EMTALA policy.
3. Services Eligible For HAP
    1. This HAP policy applies to all emergency and other medically necessary care provided by the SIH hospitals listed below, as well as certain other providers delivering emergency or other medically necessary care in SIH facilities.
        A. Addendums to this policy include a list of all providers, in addition to SIH itself, delivering emergency or other medically necessary care at SIH hospitals that specifies which providers are covered by this policy and what are not covered.

1. Addendum A: SIH Current Provider Listing
2. Addendum B: SIH Providers Who Are not Affiliated With SIH Medical Group

B. Provider listing is updated quarterly.

2. This HAP policy applies to:
   A. Memorial Hospital of Carbondale, 405 W Jackson, Carbondale, IL 62902, (618) 549-0721
   B. Herrin Hospital, 201 S 14th Street, Herrin, IL 62948, (618) 942-2171
   C. St. Joseph Memorial Hospital, 2 South Hospital Drive, Murphysboro, IL 62966, (618) 684-3156

4. HAP Eligibility Criteria
   1. The Healthcare Assistance Program applies to those patients residing in Illinois.
   2. Financially Indigent
      A. SIH classifies all patients whose income is less than or equal to 200% of the Federal Poverty Guidelines as Financially Indigent which results in 100% financial assistance.
      B. Partial Financial Assistance is provided on a sliding scale for those patients whose income is up to 6 times (600%) the Federal Poverty Guidelines.
      C. SIH utilizes the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services.
   3. Medically Indigent
      A. To be considered for classification as a Medically Indigent patient the amount owed after application of the Financially Indigent adjustment must exceed twenty five (25) percent of the patient's annual income.
      B. Patients classified as Medically Indigent are responsible for Medicare expected payment further reduced by the Financially Indigent adjustment percentage.
   4. SIH will not collect in excess of 25% of a patient's annual income in any given year.
   5. Hospital Uninsured Patient Discount Act:
      A. Uninsured patients with annual income less than or equal to 300% FPL. Under the Act their hospital bills are discounted to 100% minus 135% of Cost.
   6. Medicaid out of state
      A. Medicaid eligible patients with out of state coverage in which SIH Hospitals are not enrolled.
   7. Reservation of Rights:
      A. SIH reserves the right to limit or deny financial assistance at the sole discretion of SIH.

5. Presumptive Eligibility
   1. SIH is responsible and relies on strong cooperation with the patient to apply Presumptive Eligibility to an uninsured patient as soon as possible after receipt of hospital services and prior to issuing a bill for those hospital services. (Example 8)
   2. Designated staff follows the guidelines established in this policy with regard to the completion and processing of all Presumptive Eligibility procedures.
   3. SIH reserves the right to provide Presumptive Eligibility Assistance and use the following criterion to determine if a patient is eligible without further scrutiny by the hospital.

A. Homelessness

B. Deceased patient with no estate

C. Mentally incapacitated with no one to act on their behalf

D. Medicaid eligible, but not on date of service or for a non-covered service

E. Patients receiving the following service automatically qualify for 100% assistance without application.

1. Medicaid patients with spend-down (patient liability) responsibility
2. Medicaid patients with coverage secondary to Medicare that receive services requiring an Advance Beneficiary Notice (ABN)
3. Medicaid patients determined to be Medicaid qualified after the 180 days timely filing
4. Medicaid primary patients receiving Veni Puncture
5. Medicaid coverage on date of service but not covered on dates of service beginning with the first day of the preceding month through date of service.

F. Patients that choose to have elective cosmetic procedures are not covered under Presumptive eligibility.

1. Elective and/or services deemed not medically necessary may not be eligible for financial assistance consideration.

G. Resident of shelter facility with no insurance coverage

H. Insolvent insurance carriers under a state directive to cease and desist

I. Victims of Disaster Relief in the Southern sixteen (16) counties as determined by Management

J. Services rendered through free clinics such as Hands of Hope, Bridges Clinic and Abundant Health Services and/or Agencies which have exhausted government sponsored grants such as JCHD-HIV

4. Accounts researched and approved for Presumptive Eligibility are adjusted at 100% based on authority levels.
5. Presumptive accounts are reviewed for approval through Search America.

6. HAP Application Process

1. SIH requests each patient apply for financial assistance and complete a HAP application. (Example 1)

A. Accounts are considered for Healthcare Assistance after an exhaustive investigation of other funding sources indicates no coverage (e.g. Medicaid denies coverages, etc.)

1. Lack of completed claim form or lack of cooperation from the patient is not considered a valid denial.

B. Accounts that cannot be considered for the HAP program:

1. Accounts where the treatment provided is related to or the subject of litigation, settlement, award, or any other type of legal action.
2. Accounts that have not had other avenues of payment exhausted
3. Accounts greater than 12 months from the date the application was signed and dated

4. SIH reserves the right to request applicant pursue ABE.

C. HAP applications can be used on eligible accounts for three (3) months prior from the date the application was signed and dated.

2. SIH facilities (Memorial Hospital of Carbondale, Herrin Hospital, and St. Joseph Memorial Hospital) accept a copy of the SIH Medical Group HAP Application. A thorough review is completed.

   A. SIH has the right to request additional information when needed.

3. Applications are provided by Financial Counselors, Patient Account Representatives, other designated staff through MyChart or at www.sih.net website free of charge.

4. Immediate Family Members:

   A. The number of people in an adult patient's household includes the patient, the patient's spouse and any dependents.

   B. The number of people in a minor patient's household includes the patient, the patient's mother and any dependents of the patient's mother and the patient's father and any dependents of the patient's father.

   C. Anyone listed on the tax return as a dependent is considered part of immediate family.

5. For Final Determination SIH can:

   A. Use monthly expenses and asset information for final determination

   B. Request and review annual income, asset and expense information on a case-by-case basis

   C. Consider the extent to which the person has assets other than income that could be used to meet his or her financial obligation

   D. Request additional information upon review of the Healthcare Assistance Application

   E. Financial assistance will not be denied under HAP based on an applicant's failure to provide information or documentation not required by the hospital's HAP policy or HAP application.

   F. A social security number is not required, but will aid in the processing of application.

6. Income Verification:

   A. SIH requests the patient verify the income set forth in the Healthcare Assistance Application.

   B. Documentation Verifying Income:

      1. Income is verified through any of the following:

         a. IRS Form W-2 and Earnings Statement

         b. Pay Check Remittance

         c. Tax Returns

            i. HAP is not considered until all tax returns are completed and filed unless sufficient documentation supports income verified or supports there is no tax return.

            ii. If applicant does not have copies of their tax returns ask them to contact the IRS to obtain copies.

            iii. In the event an application is received in January, February or March and a tax return has not been filed, the previous year's tax return will be accepted.

iv. For applications received April thru December a current year tax return is required.

d. Social Security income or letter

e. Worker's Compensation or Unemployment Compensation Determination Letters

f. Telephone verification by employer of the patient's annual gross income

g. Employee wage forms or bank statements

7. Documentation Unavailable:

A. Verify income when patient is unable to provide documentation.

1. Patient signs a Healthcare Assistance Application attesting to the accuracy of the income information provided.

2. Patient signs a Healthcare Assistance Application attesting there are no open legal suits pending for any accounts in which assistance is being requested.

3. Explanation is required stating the reason the patient is unable to provide the requested documentation verifying income or monthly expenses exceed the monthly income listed and/or how expenses are being paid. (See example 3)

8. Falsification of Information:

A. Falsification of information may result in denial.

B. Financial assistance is withdrawn after a patient is granted financial assistance and material provided is found to be untrue.

9. Document Retention:

A. SIH maintains the Health Care Assistance Program application for a period of seven (7) years from the date of application.

10. If it is determined the patient is not eligible for HAP, the patient is notified by letter as to the reason for denial. *(*See examples 6 and 7)

7. Measures To Widely Publicize the HAP policy

1. Patient notification of Healthcare Assistance Program:

A. Financial Assistance notices are placed in all departments registering patients.

B. SIH posts signage in English, Spanish and Arabic regarding the availability of financial assistance.

2. SIH's website posts notice of financial assistance through the Healthcare Assistance Program and applications in English, Spanish and Arabic.

3. Information regarding HAP is available in all Patient Intake offices and in other public locations within the hospital upon request without charge.

4. Registrars inform all patients of the Healthcare Assistance Program, and offers a plain language summary.

8. Basis For Calculating Amounts Charged To Patients

1. SIH dba: Memorial Hospital of Carbondale, Herrin Hospital, and St. Joseph Memorial Hospital, use Look-back method to determine Amounts Generally Billed or AGBs.

2. The AGB percentage is based on an aggregate discount from established charges, applied to our current mix of patient services, per agreements with CMS and other third party payors.
3. The public obtains information regarding the AGBs in writing and free of charge by contacting the Director of Finance, SIH at 618-457-5200 ext. 67200.
4. A HAP eligible individual is not charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care.
5. SIH does not bill or expect payment of gross/total charges from individuals who qualify for financial assistance under this policy.
6. SIH bills for balances when less than 100% is approved.

9. Basis for calculating amounts refunded to uninsured patients.
    1. Accounts are considered for refunds under the Illinois Hospital Uninsured Patient Discount Act.
    2. SIH refunds patient payments with HAPs approved at 100% or payments exceeding patient liability and approved at less than 100%.
        A. Example:
            1. Patient makes a payment of $100.00
            2. Patient's liability is $100.00
            3. Patient is approved for 70% HAP
            4. Refund of $30.00 is issued to patient
    3. Patients with 100% approval on or after April 1, 2016 are reviewed for refund.
10. Actions Taken In The Event Of Nonpayment
    1. The actions SIH may take in the event of nonpayment are described in a separate Billing and Collections Policy.
        A. Members of the public may obtain a free copy of this separate policy from the SIH PFS department by contacting SIH at 1-800-457-1393.
11. Miscellaneous
    1. No Effect on Other Hospital Policies:
        A. This Healthcare Assistance policy does not alter or modify other policies regarding efforts to obtain payments from third-party payers, patient transfers or emergency care.
    2. Modification to this policy must be approved by:
        A. The Corporate Director of Patient Financial Services, Chief Financial Officer, Chief Executive Officer and the Board of Directors

VI. DOCUMENTATION

1. Refer to Example 2, 3 and 4 for documentation to be provided by patient.
2. Refer to Examples 1, 5, 6,7, 8, 9, 10, 11 and 12 for documents to be completed by SIH Representative.

VII. CHARGES

N/A

Replaces:

N/A

Attachments:

Example 1
Example 10 attachment.docx
Example 11 attachment.docx
Example 12 Healthcare Assistance Eligibity Notification Form.docx
Example 2 - Healthcare Assistance Application
Example 3 - Additional Information
Example 4 - Employee Wage Form
Example 5 - Discount Schedule for Applicants
Applying for Healthcare Assistance
Example 6
Example 7
Example 8
Example 9 attachment.docx

Approval Signatures

Approver	Date
Deborah Emery: CORP REGULATORY COOR	10/24/2019
Shannon Hartke: CORP DIR PFS	10/24/2019

Applicability

Southern Illinois Healthcare Corporate System

Example 1 (Print on letterhead stationery)

☐ Memorial Hospital of Carbondale
405 W. Jackson
Carbondale, IL 62902
(618) 549-0721
Ext. 64572
Fax (618) 351-6540

☐ Herrin Hospital
201 S. 14th Street
Herrin, IL 62948
(618) 942-2171
Ext. 36458
Fax-(618) 351-6540

☐ St. Joseph Memorial Hospital
2 South Hospital Drive
Murphysboro, IL 62966
(618) 684-3156
Ext. 55331
Fax (618) 351-6540

☐ SIH Medical Group
1239 East Main Street
Carbondale, IL 62901
(618) 457-5200
Ext. 67575
Fax (618) 351-6540

Dear Patient/Guarantor:

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help_____, determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, 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.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail (web site elective), or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

Please understand in order to receive assistance with your hospital bill you will need to show all payment sources such as medical insurance, Medicaid, work comp, liability, etc. All payors must be fully exhausted before healthcare assistance will be considered.

Certain circumstances in which a patient may be eligible for presumptive eligibility may not require an application. Please contact a Financial Counselor at the number above to learn more.

Please return the application with the following information:

1. A complete Healthcare Assistance Program application signed and dated.
2. A copy of your last federal tax return filed. If self employed you must include Schedule C. Please include a copy of all W2's.
3. A copy of your most recent check or check stub for employment, unemployment, Social Security, pension, workmen's compensation (or work comp determination letter) or any other source(s) of income you have received for the past thirteen (13) weeks. We will accept one of the following three documents for proof of wages:

    a. An employee wage form filled out and signed by your employers for each wage earner in the household. (see application for this form).
    b. Copies of check stubs for the last 13 weeks.
    c. A print out of your wages from your employer for the last 13 weeks.
    d. The above wage information must be approved for all family/household members.

4. If applicable, proof of participation in Governmental assistance programs such as food stamps, WIC, Medicaid, Link, school lunches, Child Care Resource or Referral Program.

5. You may be asked to apply for assistance from other appropriate sources if it is determined you could qualify for such aid.

If you want to submit an appeal of our decision or request re-consideration it must be in writing. Please include the reason or provide additional information that may be beneficial for our review.

Please mail the completed application to the address listed above for the facility where you incurred charges. Only one application is required if you have accounts at any or all of the three hospitals listed above. If you need assistance in completing the application please contact the Financial Counselor at the appropriate facility. You may reach us Monday thru Friday 8:00 am to 4:30 p.m.

Completion of this application does not relieve you of your financial obligation to Southern Illinois Healthcare; Southern Illinois Healthcare reserves the right to deny any application upon review.

Sincerely,

Financial Counselor

Example 2 – (Print on letterhead stationery)

☐ Memorial Hospital of Carbondale 405 W. Jackson Carbondale, IL 62902 (618) 549-0721 Ext. 64572 Fax (618) 351-6540	☐ Herrin Hospital 201 S. 14th Street Herrin, IL 62948 (618) 942-2171 Ext. 36458 Fax (618) 351-6540	☐ St. Joseph Memorial Hospital 2 South Hospital Drive Murphysboro, IL 62966 (618) 684-3156 Ext. 55331 Fax (618) 351-6540	☐ SIH Medical Group 1239 East Main Street Carbondale, IL 62901 (618) 457-5200 Ext. 67575 Fax (618) 351-6540

Healthcare Assistance Application

Name:_____ Date of Birth: _____

Address:_____ _____ _____ _____

Street Address/PO Box City State Zip Code

Phone Number: _____ Social Security Number _____ (not required)

Family/household information:

1. Number of persons in the patient's family/household: _____
2. Number of persons who are dependents of the patient: _____
3. Ages of patient's dependents: _____ _____ _____ _____ _____

Employment and Income Information

1. Enter patient's, patient's spouse or partner's employer information.
2. If patient is a minor, enter the patient's parent's or guardian's employer information.

Patient	Spouse	Partner	Other
Patient's Employer Name: _____ Address: _____ City, State, Zip _____ Salary :Gross Amount _____	Spouse's Employer Name: _____ Address: _____ City, State, Zip _____ Salary :Gross Amount _____	Partner's Employer Name: _____ Address: _____ City, State, Zip _____ Salary :Gross Amount _____	Other Employer Name: _____ Address: _____ City, State, Zip _____ Salary :Gross Amount _____
Patient's Employer Name: _____ Address: _____ City, State, Zip _____ Salary :Gross Amount _____	Spouse's Employer Name: _____ Address: _____ City, State, Zip _____ Salary :Gross Amount _____	Partner's Employer Name: _____ Address: _____ City, State, Zip _____ Salary :Gross Amount _____	Other Employer Name: _____ Address: _____ City, State, Zip _____ Salary :Gross Amount _____

Other Income

Other Income		Patient's Monthly Income		Spouse/Partner/Other Dependent's Monthly Income
Wages		$		$
Self -Employment		$		$
Unemployment Compensation		$		$
Social Security		$		$
Social Security Disability		$		$
Veteran's Pension/Disability		$		$
Workers' Compensation		$		$
Temporary Assistance for Needy Families		$		$
Retirement Income		$		$
Child Support, Alimony or Other Spousal Support		$		$
Other Income		$		$

Documentation of family income from paycheck stubs, benefit statements, award letters, court orders, federal tax returns, or other documentation provided by the patient.

Assets

Real Estate: Own ____ Rent _____		Bank: Checking	$
Market Value	$	Savings	$
Amount Owed:	$		
	$	Mutual Funds:	$
Auto/Truck/Type:		Stocks, CD's:	$
Market Value:	$	Rental Property Owned:	$
Motorcycles, Boats, Campers, Other Vehicles:		Other:	$
Market Value	$		$
			$
			$

Monthly Expenses

Rent or House Payments:	$	Other:	$
Utilities	$		$
	$		$
	$		$
	$		$
Child Care:	$		$
Food and Supplies:	$		$
Auto Payments:	$		$
Transportation	$		$
Credit Cards:	$		$
Property Tax: (Annual) :	$		$
		Total Monthly 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.

Y ☐ N ☐ Was the patient an Illinois resident when care was rendered by the hospital?

Y ☐ N ☐ Was the patient involved in an alleged accident?

Y ☐ N ☐ Was the patient a victim of an alleged crime?

Y ☐ N ☐ Does the applicant (s) have any active or open Law/Legal suit for accounts that assistance is being requested?

Y ☐ N ☐ Does the applicant (s) have any insurance benefits?

Date: _____ Signed: _____

Patient/Applicant

Date: _____ Signed: _____

Patient/Applicant

Example 3

ADDITIONAL INFORMATION

Please use this form to provide additional information that might aid in the processing of your Healthcare Assistance application.

If any of the following statements or questions applies to your situation, please provide the required information on this form.

1. If your monthly expenses exceed your monthly income, please note how your expenses are being met.

_____
_____
_____

2. If your tax return is not included, please explain why.

_____
_____
_____

3. If you have no income how do you support yourself?

_____
_____
_____

4. If you are receiving financial support from anyone, include a written statement how they are helping you.

5. Other:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Example 4

Employee Wage Form

(To Be Completed And Signed By Employer)

Employee Name: _____

Employee Social Security Number: _____ (not required)

Employer Name: _____Tele: _____Ext. _____

Address: _____

City State Zip Code

Wages For The Last 13 Weeks

Week	Pay Period Ending	Gross Wages
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

1. Is the employee currently working? _____(yes/no), If no, when was the last day worked? _____
2. If the employee is not currently working, will the employee be returning to work? _____ (yes/no) Expected return date _____
3. When did employment begin: _____ End: _____

I certify the wage information regarding the person named above is true and accurate.

Date: _____ Signed: _____

Signature of Employer or
Employer's Representative

Example 5

Discount Schedule For Applicants Applying for Healthcare Assistance

2019 Federal Poverty Guidelines as Published per Federal Register

1	2	3	4	5	6	7	8
$12,490	$16,910	$21,330	$25,750	$30,170	$34,590	$39,010	$43,430

Based On 2019 Poverty Guidelines

FPL @ 200% to 600% at Quarterly Income Spread

Discount	1	2	3	4	5	6	7	8
100% (at 200% of FPL)	**6,245**	**8,455**	**10,665**	**12,875**	**15,085**	**17,295**	**19,505**	**21,715**
90% (at 333% of FPL)	**10,398**	**14,078**	**17,757**	**21,437**	**25,117**	**28,796**	**32,476**	**36,155**
80% (at 466% of FPL)	**14,551**	**19,700**	**24,849**	**29,999**	**35,148**	**40,297**	**45,447**	**50,596**
70% (at 600% of FPL)	**18,735**	**25,365**	**31,995**	**38,625**	**45,255**	**51,885**	**58,515**	**65,145**

Example 6 (Print on letterhead stationery)

1239 East Main St
Carbondale, IL 62901
Phone: (800)-457-1393
Fax: (618) 351-6540

DATE

GUARANTOR NAME
ADDRESS
CITY, STATE ZIP CODE

Dear GUARANTOR NAME:

With regret we must notify you that your application for Healthcare Assistance cannot be approved at this time. It was determined that you do not meet the eligibility requirements for the following reason(s):

___Verification of Income:

___Incomplete or missing information

___Exceeds income criteria for the Healthcare Assistance Program

Requests for re-consideration can be submitted within 30 days. Please submit the request to the address listed above, online at http://mychart.sih.net, or fax to (618) 351-6540. If you need assistance please contact a Customer Service Representative at 1-800-457-1393.

Sincerely,

Southern Illinois Healthcare Representative

Example 7 (Print on letterhead stationery)

1239 East Main St
Carbondale, IL 62901
Phone: (800)-457-1393
Fax: (618) 351-6540

DATE

GUARANTOR NAME
ADDRESS
CITY, STATE ZIP CODE

Dear GUARANTOR NAME,

Your application for the Healthcare Assistance Program has been processed and approved. The approval is valid from **EFFECTIVE DATE** to **EXPIRATION DATE.**

Your account balance(s) will be reduced by 70%.

The Healthcare Assistance adjustment has been applied to your account(s) for Southern Illinois Hospital Services. Your remaining balance(s) will be reflected in one of the following: MyChart, SIH billing statement, or in a statement from an extension of our business office - Avadyne Health.

If you have any questions regarding your account(s), please contact a Customer Service Representative at 1-(800)-457-1393.

Sincerely,

Shannon Hartke, MBA, FHFMA
Corporate Director
Patient Financial Services

Patients eligible for financial assistance are not charged more for emergency or other medically necessary care than patients who are covered by Medicare or other health insurance. This limitation is reflected in your balance due. If you would like further information regarding this limitation, please contact us at 1-(800)-457-1393.

Example 8

1239 East Main St
Carbondale, IL 62901
Phone: (800)-457-1393
Fax: (618) 351-6540

DATE

GUARANTOR NAME
ADDRESS
CITY, STATE ZIP CODE

Dear GUARANTOR NAME,

Your application for the Healthcare Assistance Program has been processed and approved. The approval is valid from **EFFECTIVE DATE** to **EXPIRATION DATE.**

Your account balance(s) will be reduced by 80%.

The Healthcare Assistance adjustment has been applied to your account(s) for Southern Illinois Hospital Services. Your remaining balance(s) will be reflected in one of the following: MyChart, SIH billing statement, or in a statement from an extension of our business office - Avadyne Health.

If you have any questions regarding your account(s), please contact a Customer Service Representative at 1-(800)-457-1393.

Sincerely,

Shannon Hartke, MBA, FHFMA
Corporate Director
Patient Financial Services

Patients eligible for financial assistance are not charged more for emergency or other medically necessary care than patients who are covered by Medicare or other health insurance. This limitation is reflected in your balance due. If you would like further information regarding this limitation, please contact us at 1-(800)-457-1393.

Example 9

1239 East Main St
Carbondale, IL 62901
Phone: (800)-457-1393
Fax: (618) 351-6540

DATE

GUARANTOR NAME
ADDRESS
CITY, STATE ZIP CODE

Dear GUARANTOR NAME,

Your application for the Healthcare Assistance Program has been processed and approved. The approval is valid from **EFFECTIVE DATE** to **EXPIRATION DATE.**

Your account balance(s) will be reduced by 90%.

The Healthcare Assistance adjustment has been applied to your account(s) for Southern Illinois Hospital Services. Your remaining balance(s) will be reflected in one of the following: MyChart, SIH billing statement, or in a statement from an extension of our business office - Avadyne Health.

If you have any questions regarding your account(s), please contact a Customer Service Representative at 1-(800)-457-1393.

Sincerely,

Shannon Hartke, MBA, FHFMA
Corporate Director
Patient Financial Services

Patients eligible for financial assistance are not charged more for emergency or other medically necessary care than patients who are covered by Medicare or other health insurance. This limitation is reflected in your balance due. If you would like further information regarding this limitation, please contact us at 1-(800)-457-1393.

Example 10

1239 East Main St
Carbondale, IL 62901
Phone: (800)-457-1393
Fax: (618) 351-6540

DATE

GUARANTOR NAME
ADDRESS
CITY, STATE ZIP CODE

Dear GUARANTOR NAME:

Your application for the Healthcare Assistance Program has been processed and approved. The approval is valid from **EFFECTIVE DATE** to **EXPIRATION DATE**.

Your account balance(s) will be reduced by 100% for Southern Illinois Hospital Services.

If you have any questions regarding your account(s), please contact a Customer Service Representative at 1-(800)-457-1393.

Sincerely,

Shannon Hartke, MBA, FHFMA
Corporate Director
Patient Financial Services

Patients eligible for financial assistance are not charged more for emergency or other medically necessary care than patients who are covered by Medicare or other health insurance. This limitation is reflected in your balance due. If you would like further information regarding this limitation, please contact us at 1-(800)-457-1393.

Example 11

1239 East Main St
Carbondale, IL 62901
Phone: (800)-457-1393
Fax: (618) 351-6540

DATE

GUARANTOR NAME
ADDRESS
CITY, STATE ZIP CODE

Dear GUARANTOR NAME:

Thank you for your Healthcare Assistance Program (HAP) application. We are missing the following information which is very important for the completion of the review of your application.

__1. A copy of last year's complete federal tax return. If self employed you must include Schedule C.

__2. A copy of your W2 Wage and Tax Statement filed with your tax return.

__3. A copy of your checks or check stubs for Social Security, pension, unemployment, all places of employment, workmen's compensation or any other source(s) of income you have received for the past 90 days.

__4. If applicable, proof of participation in Governmental assistance programs such as food stamps, WIC, Medicaid, Social Security, or Worker's Compensation determination letters.

__5. A completed Employee Wage form from all employees for each wage earner in the household.

__6. A copy of acceptance or valid denial from the Illinois Department of Public Aid, if your hospital bill(s) has a balance or combined balances of over $1500.00.

Please submit the additional information to the address listed above, online at http://mychart.sih.net, or fax to (618) 351-6540 within 30 days. If you need assistance please contact a Customer Service Representative at 1-800-457-1393.

Sincerely,

Southern Illinois Healthcare Representative

Example 12

Healthcare Assistance Eligibility Notification Form

In cooperation with Southern Illinois Hospital Services, d.b.a., Memorial Hospital of Carbondale and in accordance with Illinois State Law, I hereby acknowledge I have been informed financial assistance may be available thru the Healthcare Assistance Program. I also understand I must assist the hospital to help me (the patient) determine if I may qualify for financial assistance.

A Healthcare Assistance Application may not be required if certain qualifying conditions are met. I understand that I am responsible to promptly notify the hospital if I am covered by Medicaid or any other governmental program. I also understand that I am required to disclose any pending litigation or court settlement that may be used to pay for the services rendered by the hospital.

I acknowledge I was offered a Healthcare Assistance Plain Language Summary Document and was given the opportunity to ask questions.

_____ Date:_____ Time:_____

Signature of Patient (or Personal Representative/Agent)

☐ Unable to sign due to medical condition

_____ _____

Printed Name of Legal Representative Relationship to Patient

_____ Date: _____ Time: _____

Witness