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Last Reviewed	10/19/2026	Applicability	Harrisburg Medical Center
Due For Review	10/19/2027		

Healthcare Assistance Program and Presumptive, HB-PI-092

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Applies to:

Patient Access

I. POLICY

Consistent with Harrisburg Medical Center's mission, vision, values, and strategic plan, HMC 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. HMC 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 billed for emergency or other medically necessary care to individuals who have insurance coverage

Assignment of Benefits: Language present on an insurance card indicating that by accepting the insurance plan for payment at the time of service we are agreeing to all the insurance plan's terms and to

accept whatever reimbursement they determine to be acceptable.

Application Period: An individual may apply for Healthcare Assistance by completing the Healthcare Assistance Program Application prior to service or from the date of service through the 240th day after the first guarantor billing statement. This is known as the Application Period

Bill: HMC utilizes data 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

Epic - Electronic Medical Record used to bill or follow-up on patient accounts and scan information received or printed on behalf of a patient

Deeming Period: A temporary period during which a D-SNP member who has lost Medicaid eligibility may remain enrolled in the D-SNP while Medicaid eligibility is being reviewed or reestablished. During the Deeming Period, the member may retain Medicare coverage through the D-SNP but may no longer have active Medicaid coverage. The Deeming Period ends when Medicaid eligibility is reinstated or the member is determined to no longer qualify for continued D-SNP enrollment.

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

FPL: Federal Poverty Level

Financial Counselor: HMC 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

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

HMC - Harrisburg Medical Center

Healthcare Assistance Application: an application which allows for the collection of information for Healthcare Assistance consideration (See Examples 01-05)

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

Healthshare Plans: Medical cost sharing organizations where members make monthly payments into a shared pool. When a member incurs a qualified medical expense, the claim is reimbursed from the pool. Healthshare plans are NOT insurance and are not governed by state or federal insurance regulations.

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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 HMC 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

Medicare Savings Program: Medicare programs to help individuals with limited income cover their healthcare costs. Medicare Savings Programs only apply to qualified Original Medicare beneficiaries with Part A and Part B coverage and do not apply to Medicare Advantage or Medicare HMO beneficiaries. Medicare Savings Programs include the following programs, 1) Qualified Individuals (QI) to cover Part B premiums 2) Qualified Medicare Beneficiary (QMB) to cover Part A and Part B deductible, Part B premiums, coinsurance and copay costs, 3) Qualified Disabled and Working Individuals (QDWI) to cover Part A premiums, and 4) Specified Low-Income Medicare Beneficiaries (SLMB) to cover Part B premiums.

Ninety (90) Days: the number of days a patient will not be billed, or account sent to Bad Debt/Collection

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 HMC 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

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Propensity to Pay: 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

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

SIH - Southern Illinois Healthcare

Total yearly income: the sum of the yearly gross income

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

Victims of Violent Crimes - The victim of a violent crime who generally meets the eligibility requirements in the Illinois Crime Victims Compensation Program.

III. RESPONSIBILITIES

1. All staff are required to follow the guidelines established within this policy regarding 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. HMC provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this HAP policy.
        A. HMC hospital 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 HMC patients in a non-discriminatory manner, pursuant to each hospital's respective EMTALA policy.
3. Services Eligible For HAP

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1. This HAP policy applies to all emergencies and other medically necessary care provided by the SIH HMC hospitals listed below, as well as certain other providers delivering emergency or other medically necessary care in SIH HMC facilities.
    A. Addendums to this policy include a list of all providers, in addition to HMC itself, delivering emergency or other medically necessary care at HMC hospitals that specifies which providers are covered by this policy and what are not covered.
        1. HMC Current Provider Listing
        2. HMC Providers Who Are Not Affiliated with HMC
        3. Provider Lists can be located at www.sih.net
    B. Provider Lists are updated quarterly.
2. This HAP policy applies to:
    A. Harrisburg Medical Center, 100 Dr Warren Tuttle Dr, Harrisburg, IL 62946, (618)253-7671

4. HAP Eligibility Criteria
    1. The Healthcare Assistance Program applies to those patients residing in Illinois or has a temporary visitors driver's license at time services rendered.
    2. Financially Indigent
        A. HMC 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 six times (600%) the Federal Poverty Guidelines.
        C. HMC 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 not exceed 20% 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. Applications for patients that have been registered self-pay due to assignment of benefit language on the card and/or identified with a non-traditional healthshare/ Medishare plan will be processed as normal. Accounts will be reviewed by financial counselors to approve or deny individually according to payment and documentation received.
    5. HMC will not collect more than 20% of a patient's annual income in any given year.
    6. Hospital Uninsured Patient Discount Act:

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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.

7. Medicaid out of state
    A. Medicaid eligible patients with out of state coverage in which HMC Hospitals are not enrolled.

8. Reservation of Rights:
    A. HMC reserves the right to limit or deny financial assistance at the sole discretion of HMC.
    B. Financial Assistance may be applied to uninsured patients, as well as the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary hospital services permitted that the patient meets the FPL guidelines stated above.
    C. Complaints or concern with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at www.illinoisattorneygeneral.gov/consumers/hcform.pdf or 1-877-305-5145.

5. Presumptive Eligibility
    1. HMC 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.
    2. Designated staff follow the guidelines established in this policy regarding the completion and processing of all Presumptive Eligibility procedures.
    3. HMC 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. Bankruptcy
        D. Emancipated Minor
        E. Mentally incapacitated with no one to act on their behalf
        F. Victims of Violent Crimes
        G. Medicaid eligible, but not on date of service or for a non-covered service
        H. 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

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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 Venipuncture
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.
6. Medicaid patients with Medicaid Immigrant Co-pays

I. 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.

J. Resident of shelter facility with no insurance coverage

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

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

M. Services rendered through free medical clinics or agencies which have exhausted government sponsored grants such as JCHD-HIV

N. Individuals incarcerated in Federal Prison in which all efforts have been exhausted for any third-party liability in which patient has a remaining patient liable amount and no available monetary resources.

O. Patients eligible for Medicare Savings Programs on date of service.

4. Accounts researched and approved for Presumptive Eligibility are adjusted at 100% based on authority levels.
5. Presumptive accounts are reviewed for approval through Propensity to Pay.
6. Non-covered and denied services provided to Medicaid eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability except their share of cost obligations and all charges related to services not covered, including all denials, are charity care. Examples may include, but are not limited to:
    a. Services provided to Medicaid beneficiaries with restricted Medicaid (i.e. patients that may only have pregnancy or emergency benefits but receive other hospital care).
    b. Medicaid or other indigent care program denials.
    c. Charges related to days exceeding a lengthy-of-stay limit
    d. Medicaid claims (including out of state Medicaid claims) with "no payment".
    e. Medically necessary service (s) provided to a Medicaid eligible patient with no coverage and no payment.

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7. D-SNP members who lose the Medicaid portion of their coverage and enter a Deeming Period are eligible for 100% Presumptive Eligibility assistance without application. Presumptive Eligibility will remain in effect during the Deeming Period until Medicaid coverage is reinstated or the member is determined to no longer qualify for D-SNP coverage.

6. HAP Application Process
    1. An individual can apply for Healthcare Assistance in the Application Period for services which are medically necessary.
    2. HMC requests each patient apply for financial assistance and complete a HAP application. (See Examples 01-05)
        A. Accounts are considered for Healthcare Assistance after an exhaustive investigation of other funding sources indicates no coverage (e.g., Medicaid denies coverage, 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. Services which are deemed elective in nature, cosmetic, priced at retail levels, or deemed not medically necessary in nature.
            2. Accounts where the treatment provided is related to or the subject of litigation, settlement, award, or any other type of legal action.
            3. Accounts that have not had other avenues of payment exhausted
            4. Accounts greater than 12 months from the date the application was signed and dated
            5. HMC 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.
    3. HMC facility (Harrisburg Medical Center) accepts a copy of the SIH Medical Group HAP Application. A thorough review is completed.
        A. HMC has the right to request additional information when needed.
        B. HAP adjustments given by SIH facilities (Memorial Hospital of Carbondale, Herrin Hospital, and St Joseph Memorial Hospital) may be honored under this policy. A thorough review is completed.
    4. Applications are provided by Financial Counselors, Patient Account Representatives, and other designated staff at www.sih.net website free of charge.
    5. 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,

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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.

6. For Final Determination HMC 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.
7. Income Verification:
    A. HMC 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. Paycheck 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 applicants do 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 through December a current year tax return is required.
            d. Social Security income or letter

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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

8. 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 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 03)
9. Falsification of Information:
    A. Falsification of information may result in denial.
    B. Financial assistance is withdrawn after a patient is granted financial assistance and the material provided is found to be untrue.
10. Document Retention:
    A. HMC maintains the Health Care Assistance Program application for a period of seven (7) years from the date of application.
11. If it is determined the patient is not eligible for HAP, the patient is notified by letter as to the reason for denial. (See Example 06)

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. HMC posts signage regarding the availability of financial assistance.
    2. HMC's website posts notice of financial assistance through the Healthcare Assistance Program and applications.
    3. Electronic applications are also available on MyChart by logging on and selecting Billing and then selecting Financial Assistance.
    4. Information regarding HAP is available in all Patient Intake offices and in other public locations within the hospital upon request without charge.
    5. Registrars inform all patients of the Healthcare Assistance Program and offer a plain language summary.

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8. Basis For Calculating Amounts Charged to Patients
    1. Harrisburg Medical Center uses the 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 billed to individuals who have insurance covering such care.
    5. HMC does not bill or expect payment of gross/total charges from individuals who qualify for financial assistance under this policy.
    6. HMC 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. HMC 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 September 17, 2023, are reviewed for refund.
10. Actions Taken in the Event of Nonpayment
    1. The actions HMC 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 at www.sih.net or from the HMC PFS department by contacting 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:

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A. The Corporate Director of Patient Financial Services, Chief Financial Officer, Chief Executive Officer, and the Board of Directors.

B. Professional Judgment: CFO and/or Corporate Director of Patient Financial Services may under their sole discretion apply Healthcare Assistance adjustment(s) on a case-by-case basis.

VI. DOCUMENTATION

1. Refer to Examples 02, 03, 04, and 17 for documentation to be provided by patient.
2. Refer to Examples 01, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, and 16 for documents to be completed by SIH HMC Representative.

VII. CHARGES

N/A

Replaces:

N/A

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Attachments

- Example 01 - Healthcare Assistance Program Application Instructions
- Example 02 - Healthcare Assistance Program Application
- Example 03 - Additional Information
- Example 04 - Employee Wage Form
- Example 05 - Discount Schedule for Applicants Applying for Healthcare Assistance
- Example 06 - Healthcare Assistance Program Denial Letter
- Example 07 - Healthcare Assistance Program Approval Letter 70%
- Example 08 - Healthcare Assistance Program Approval Letter 80%
- Example 09 - Healthcare Assistance Program Approval Letter 90%
- Example 10 - Healthcare Assistance Program Approval Letter 100%
- Example 11 - Healthcare Assistance Program Missing Information Letter
- Example 12 - Healthcare Assistance Eligibility Notification Form
- Example 13 - Healthcare Assistance Program SBO Healthshare Assign Benefits Additional Info

Example 14 - Healthcare Assistance Program Healthshare 100%

Example 15 - Healthcare Assistance Program Healthshare Assign Benefits 90% Approval

Example 16 - Healthcare Assistance Program Healthshare Assign Benefits 80% Approval

Example 17 - Healthcare Assistance Program Healthshare Assign Benefits 70% Approval

Example 18 - Healthcare Assistance Letter of Support.pdf

Self Employment Interim Finanical Statement example 19.pdf

Approval Signatures

Step Description	Approver	Date
	Andrew Ziramba: Regulatory Coordinator	10/19/2026
Chair, SIH-Board of Trustees	Daniel Booth: Chair, SIH Board of Trustees [JS]	10/19/2026
	John Antes: President/CEO	10/19/2026
	Warren Ladner: SR VP & CFO	10/19/2026
	Shannon Hartke: Director, Revenue Cycle	10/14/2026
	Jennifer Durham: Director, Revenue Cycle Cash/HMC PFS	10/14/2026
	Julie Gwaltney: Director, Patient Access	10/13/2026
	Brittni Hankins: Manager, Patient Access/HH and HMC	10/9/2026

Applicability

Harrisburg Medical Center