CentegraHealthSystem

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%

		100% FA Discount	80% FA Discount	70% FA Discount
Family Size	**2018 FPL Guidelines**	**200% FPL**	**350% FPL**	**600% FPL**
1	$ 12,140	$ 24,280	$ 42,490	$ 72,840
2	$ 16,460	$ 32,920	$ 57,610	$ 98,760
3	$ 20,780	$ 41,560	$ 72,730	$ 124,680
4	$ 25,100	$ 50,200	$ 87,850	$ 150,600
5	$ 29,420	$ 58,840	$ 102,970	$ 176,520
6	$ 33,740	$ 67,480	$ 118,090	$ 202,440
7	$ 38,060	$ 76,120	$ 133,210	$ 228,360
8	$ 42,380	$ 84,760	$ 148,330	$ 254,280
For family units of more than eight persons, add $4180 for each additional person.				
The FPL Guidelines for 2018 are effective February 8, 2018.				

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
P. O. Box 1990
Woodstock, IL 60098

Financial Assistance Coord.
(815)334-5578 ph., (815)334-5039 fax
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 www.centegra.org/billing-new
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.

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FINANCIAL ASSISTANCE APPLICATION **VISIT ID(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: _____ E-mail 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

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

ASSETS:	PATIENT	SPOUSE/PARTNER
Savings Account	☐ Yes ☐ No	☐ Yes ☐ No
Checking Account	☐ Yes ☐ No	☐ Yes ☐ No
Stocks / Bonds	☐ Yes ☐ No	☐ Yes ☐ 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

CentegraHealthSystem
P.O. Box 1990
Woodstock, IL 60098

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**

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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: _____

Your 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**