

ROCKFORD MEMORIAL HOSPITAL FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES UNINSURED

Rockford Memorial Hospital follows the Illinois Hospital Uninsured Patient Discount Act. Healthcare services are provided regardless of the patient's ability to pay for such care. These guidelines are intended to provide a framework to offer assistance to patients and families with legitimate financial hardship, who are unable to pay for all or a portion of their medical care.

When a patient or responsible individual acting on behalf of the patient, indicates an inability to pay for needed medical services, they will be asked to complete a Financial Disclosure Sheet. Any assistance from the Healthcare Family Services, Social Security office or other available funding should be pursued before the RMH application will be considered. A denial from Public Aid for failure to cooperate will result in a denial from RMH. Federal Poverty Guidelines will be used to help determine eligibility.

COVERED SERVICES

Covered services are those which are determined medically necessary by a physician.

EXCLUDED SERVICES

General dental, Cosmetic, Guest trays, Private room (unless medically necessary or no other room available.)

The following guidelines will be used to determine eligibility for financial assistance:

1. Uninsured patient without any health insurance or coverage. Patients with high deductible health plans are not eligible.
2. Must be an Illinois resident.
3. Must have family income that is no more than 600% of the Federal Poverty Guidelines.
4. Charges will be discounted to 135% of hospital cost.
5. Applicable only to charges exceeding \$300 in any one inpatient admission or outpatient encounter.
6. Maximum amount collected in a 12-month period from an eligible patient is 25% of family's annual gross income. For any subsequent services to be included in the maximum, the patient must inform the hospital that he/she received prior services from RMH which were determined to be eligible for discount.
7. RMH may exclude a patient from the 25% maximum collectible amount who has substantial assets.
8. Services must be medically necessary as defined by a physician.
9. The discount does not apply to physician services.
10. Patients are required to apply for government or other public programs if there is reason to believe they would qualify.
11. Patient must apply for the discount within 60 days of service.
12. Patients must provide third party verification of income, information regarding assets and documentation of residency within 30 days of request.
13. Income documentation shall include the following: copy of most recent tax return, copy of most recent W-2 form and 1099 form; copies of two most recent pay stubs, written income verification from an employer if paid in cash, or one other reasonable form of verification acceptable to RMH.
14. Review of credit bureau report to verify outstanding assets.
15. Amounts already paid will not be considered for financial assistance or eligible for refund.
16. Accounts previously referred to outside collection agencies will not be considered eligible.
17. Falsification of information provided will result in the discount forfeited and the patient will be responsible for charges.

ANY QUESTIONS, PLEASE CALL: (815) 971-4170 or (800) 987-4170

PLEASE RETURN THE COMPLETED FORM TO:

**Rockford Memorial Hospital
Patient Financial Services
2400 N Rockton Ave
Rockford, IL 61103**

<u>Net Income</u>	<u>Per Month</u>	<u>Additional Income</u>	<u>Value/Balance</u>	<u>Contribution</u>
Guarantor	\$ _____	I R A / CD	\$ _____	\$ _____
Spouse	\$ _____	401 K PLAN	\$ _____	\$ _____
Other (describe)	\$ _____	SOCIAL SECURITY	\$ _____	\$ _____
Total Income	\$ _____	WORKERS COMP	\$ _____	\$ _____
	\$ _____	PENSION	\$ _____	\$ _____
		OTHER	\$ _____	\$ _____

Identify and list number of dependents as shown on tax return: _____

<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Expenses:	Per Month
Rent/Mortgage	\$ _____
Home Equity Value \$ _____	\$ _____
Car(s) Make Year Model	
_____	\$ _____
_____	\$ _____
Food	\$ _____
Gasoline for Transportation	\$ _____
Heat	\$ _____
Electric	\$ _____
Telephone/Cell	\$ _____
Auto Insurance	\$ _____
Cable	\$ _____

Other Expenses: (Please List)	
_____	\$ _____
_____	\$ _____
_____	\$ _____

By signing below, you certify on behalf of yourself and your household to Rockford Health System, and authorize Rockford Health System to proceed, as follows:

1. The information provided on this Application is true, accurate and complete to the best of my knowledge;
2. Rockford Health System may obtain a personal credit bureau report to verify outstanding financial obligations;
3. Rockford Health System has the right to verify all information provided with this application, including communications with third parties; and
4. No member of my household carries any insurance that would pay for any portion of any financial obligation we may have to Rockford Health System; OR, we have provided all relevant information regarding our insurance to Rockford Health System.

Patient/Guarantor Signature

Date

Spouse's Signature

Date

By your signature above you authorize Rockford Memorial Hospital to obtain a personal credit bureau report to verify outstanding financial obligations.