

COPIES ARE ONLY VALID ON THE DAY PRINTED-OFFICIAL POLICY RESIDES IN MCN

SYSTEM: Hospital Sisters Health System	MANUAL(S): Executive Manual
TITLE: Financial Assistance Program	ORIGINATING DEPARTMENT: Fiscal Services
EFFECTIVE DATE: January 1, 2012	REVISION DATE(S): January 15, 2015
SUPERCEDES: #F-11 2/9/09, 7/89, A-27, #A-1563 3/86, #A-43	

I. POLICY:

Hospital Sisters Health System and each affiliated Local System's (HSHS) mission and values encourage reaching out to people in the communities we serve to provide care to all persons, including individuals and families with financial limitations. We are committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for government programs, or otherwise unable to pay for urgent or emergent medical care based on their individual financial situation.

The HSHS Financial Assistance Program is not a substitute for personal responsibility. Patients are expected to cooperate with HSHS' procedures for obtaining financial assistance and to contribute to the cost of their care based on their individual ability to pay. HSHS established the provisions in this Financial Assistance Program policy in order to manage financial resources in a responsible manner and to assist patients in need.

II. PURPOSE:

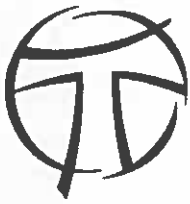
The Financial Assistance Program policy allows HSHS to determine eligibility for financial assistance for patients who meet the established eligibility criteria. This policy does not offer a provision for assistance to patients with sufficient means who refuse to pay for the medical services rendered to them or to their family members. The Financial Assistance Program is intended to help patients resolve their HSHS medical balances after exhausting all other financial options. The policy also identifies steps HSHS will take to communicate the availability of financial assistance. Any information gathered by HSHS during this process is subject to HSHS' policies on protection of confidential information.

Provisions of the policy are intended to satisfy applicable State and Federal requirements relating to charity care and specifically requirements under the Illinois' Hospital Uninsured Patient Discount Act.

III. DEFINITIONS:

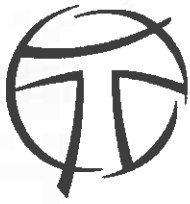
For the purposes of this policy, the terms below are defined as follows:

- A. **Assets:** Property of all kinds, real and personal, tangible and intangible that is legally applicable or subject to the payment of the patient's debts, including, but not limited to, cash on hand, checking and savings accounts, vehicles, mineral rights, stocks, mutual funds, lines of credit and any other investments; provided, however, that "income," as defined herein, shall not be included in determination of assets.
- B. **Charity:** The charges for free or discounted medical services provided to individuals who meet certain financial criteria.



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- C. **Family:** Defined by the Census Bureau as a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service's rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.
- D. **Family Income:** Income is the total annual cash receipts from all sources, before taxes, less payments made for child support which includes, but is not limited to; wages and salaries before deductions, tips, net receipts from non-farm self-employment income, net receipts from farm self-employment, social security payments, railroad retirement, unemployment compensation, workers compensation benefits, veteran's payments, public assistance payments, Supplemental Security Income, Social Security Disability Income, alimony, military allotments, private pensions, government pensions, annuity payments, grants, fellowships, dividends, interest, net rental income, net payments, net gambling or lottery winnings, assistance from outside the household and other miscellaneous sources. Noncash benefits (such as food stamps, housing subsidies and child support) do not count as income.
- E. **Federal Income Poverty Guidelines:** The most recent published federal income poverty guidelines for a household, which shall be revised and attached to this policy when they are published by the U.S. government.
- F. **Health care services:** Medical services provided to the individual within the HSHS's environment, including, but not limited to, medical diagnostic and surgical services as well as room and board; outpatient diagnostic environment, including but not limited to Diagnostic services, Therapeutic Services and Chronic Support Services inclusive of use of equipment, supplies, professional services (excluding non-HSHS physicians).
- G. **Hospital Uninsured Patient Discount Act:** An Illinois law requiring hospitals in Illinois to give most uninsured patients a discount on their medical bills. The act requires patients to apply for the discount within 60 days of receiving their initial medical bill.
- H. **Legal guardian:** A recognized legal surrogate for the patient with regard to medical and financial decisions, who would be authorized under Illinois law to receive confidential health care information on the patient. This includes parents who are legally responsible for their minor children, close family members who are recognized by the patient or Illinois law as having the legal ability to act on the patient's behalf with regard to medical and/or financial decisions, or a legal guardian under Illinois law.
- I. **Medically indigent charity care:** Health care services rendered in the absence of sufficient financial resources to cover the costs of care without catastrophic affect upon the individual family, in the absence of catastrophic health care coverage, and to those without third party insurance, which precludes the ability of the individual to pay for services, regardless of income level.
- J. **Medically necessary services:** Health care services for a condition which, if not promptly treated would lead to an adverse change in the health status of an individual; Emergency medical services provided in an emergency room setting; Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and medically-necessary services, evaluated on a case-by-case basis at HSHS's discretion.
- K. **Responsible party:** The patient or any individual legally obligated to pay for the patient's debts for medical care, excluding third party payers. An adult patient, living in the household of a relative other than a spouse – including an adult, unmarried child living at home – will be considered the "responsible party" for purposes of this policy, without regard to the assets and income of the other relatives living in the household (except a spouse).



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- L. **Third party payer:** Any financial agent or entity, such as an insurance carrier, HMO, employee benefit plan or government payer, with a legally enforceable obligation to pay for services billed to patient by HSHS. Responsible parties, as defined herein, are not considered third party payers.
- M. **Underinsured:** The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.
- N. **Uninsured:** The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

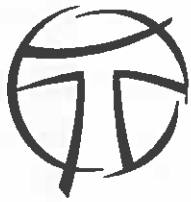
IV. GUIDELINES/PROCEDURES

Financial Counseling

- 1. Patient Financial Services and Patient Access colleagues or their designees are responsible for assisting patients and their families in determining eligibility and applying for federal, state and local insurance programs and/or for the Financial Assistance Program. If applicable, referral for debt counseling is made. Information will be made available at all patient access locations, including the emergency departments.
- 2. A standard financial information worksheet is used to collect and document the patient's insurance and financial status. The standard worksheet is reviewed as needed, but at least annually, by System Vice President of Revenue Cycle or designees. Any changes to the standard work sheet are communicated to each Local System for immediate implementation and distribution.
- 3. Patient cooperation is necessary for determination of eligibility in the HSHS Financial Assistance Program.
- 4. All uninsured patients are provided a Community Service Adjustment of 25% at the time of billing. This discount will be an administrative adjustment, not a charity adjustment. Each Local System will determine if the patient is able to qualify for a higher discount level based on the individual communities they serve, but at no point will the adjustment be less than 25% of the total billed charges. In the event a patient is later approved for a charity adjustment, the corresponding Community Service Adjustment will be reversed and the amount will be applied to a charity write-off.
- 5. All Local Systems will have colleagues or delegates available to assist patients in understanding charity and financial assistance policies.

Eligibility Criteria

- 1. Financial assistance under this policy is available without regard to the patient's race, color, creed, national origin, age, disability, handicap status, health care condition, sexual orientation or marital status.
- 2. Patients seeking financial assistance are required to seek appropriate medical care in the medical facilities closest to their actual residence. In the event appropriate treatment is not available in their community, the patient may be pre-approved for medically necessary services under the HSHS Financial Assistance Program. To determine residency, HSHS requires valid state-issued identification, a utility bill received within the last 60 days, a lease agreement, a vehicle registration card, a voter registration card or mail addressed to the patient from a local, state or federal government entity.

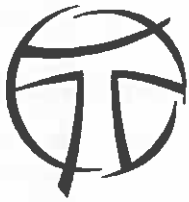


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3. Patient care, which is not medically necessary, including elective, cosmetic, or other care deemed to be generally non-reimbursable by traditional insurance carriers and government payers shall not be considered eligible for financial assistance.
4. Minor Children/Divorced Parents – for the minor children of divorced parents, when both parents/legal guardians are responsible parties, information regarding both parents will be required to complete a Financial Assistance Application. However, if after reasonable efforts, circumstances prevent the applicant from obtaining financial information for all responsible parties, information from responsible parties residing in the same household of the minor child/children will be used to make the determination.
5. Financial assistance provided by HSHS under this policy is secondary to all other third parties and financial resources available to the patient. This includes, but is not limited to :
 - a. Group or individual medical insurance plans
 - b. Employee benefit plans
 - c. Worker's Compensation plans
 - d. Medicaid, State or County Medical programs
 - e. Other state, federal or medical programs
 - f. Third parties adjudged to be legally liable for a patient's medical expenses (e.g. auto accidents or personal injury claims)
 - g. Any other persons or entities that have a legal responsibility to pay for the medical services
 - h. Crime Victims Fund (if applicable)
 - i. Medical care cost covered by government programs of other countries

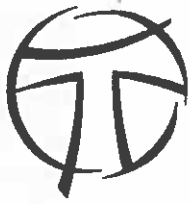
Application Process for Financial Assistance Program

1. All patients (or their legal guardians) desiring consideration for HSHS's Financial Assistance Program must apply for assistance in writing prior to or at the time of admission or prior to discharge if possible. Patients will also be allowed to apply for consideration under the HSHS Financial Assistance Policy prior to account placement at a bad debt collections agency. HSHS may request an account to be returned from a bad debt collection agency if a patient is approved for financial assistance provided the account was sent to a bad debt agency within the twelve months prior to the date of application approval date.
2. The instructions required to complete the Financial Assistance application will be furnished to patients, their legal guardians, or any persons authorized to act on behalf of the patient. HSHS will provide access to colleagues or delegates to assist patients/legal guardians in understanding the criteria for eligibility and how to fill out the application.
3. The patient and/or responsible party will be given at least sixty (60) days following the date of discharge or date of service to complete and return the Financial Assistance application.
4. When considering a financial assistance application, HSHS may request the patient first pursue other resources of payment, including but not limited to Medicaid, county or state medical assistance, Crime Victims' fund, Supplemental Social Security Income or Disability Income (SSI or SSDI), or other third-party payers as appropriate. If the patient is unwilling to pursue other potential third-party payment sources in a timely manner, HSHS will not consider the patient's request for financial assistance.
5. The patient (or their legal guardians) must disclose financial information that HSHS considers pertinent to the determination of the patient's eligibility for financial assistance.



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6. If requested by HSHS, patients (or their legal guardians) requesting financial assistance must authorize HSHS to make inquiries of employers, banks, credit bureaus, and other institutions for the purpose of verifying information HSHS requires in order to determine eligibility for financial assistance.
7. The completed Financial Assistance Program application must be accompanied by legible and accurate photocopies of the following documents, as needed, for purposes of verifying eligibility:
 - a. Complete IRS tax returns for the most recently completed calendar year of all responsible parties
 - b. Payroll check stubs or bank statements or other documentation of monthly income sources reflecting income of all responsible parties for at least the three months prior to the application;
 - c. Written verification from public assistance agencies, such as Medicaid or county medical, reflecting denials for eligibility (upon request) and as appropriate;
 - d. Written verification of denial for unemployment or worker's compensation benefits (upon request) and as appropriate.
8. Income will be annualized, when appropriate, based upon documentation provided.
9. Confidentiality of information will be maintained for all who seek and/or receive assistance under the HSHS Financial Assistance Program, as required by HSHS policies and federal and state laws. Copies of all supporting documents will be kept with the application form until destroyed in accordance with HSHS policies and federal and state document retention laws.
10. Patient Financial Services or designated representatives may interview the patient or responsible party and request completed Financial Assistance Form to determine the need and eligibility for charity.
 - a. HSHS may request additional documentation and/or information to verify eligibility for financial assistance and to complete the processing of the application.
 - b. If HSHS determines that any material documentation or information submitted is untrue or falsified, the application for the Financial Assistance Program will be denied. HSHS will not reconsider an application if representatives of HSHS determine that the applicant has intentionally misrepresented material information related to eligibility criteria or documentation.
11. Accounts returned by the collection service due to the debtor's lack of income or assets will qualify for charity status due to their inability to pay or being deemed medically indigent by the independent collection service. In addition, patients for whom we receive discharge confirmation of Chapter 7 bankruptcy through a Federal Bankruptcy Court will also qualify for 100% charity.
12. Based upon the financial assessment by the HSHS Medical Group, HSHS shall recognize the financial review as a basis for adjusting the hospital bill to charity consistent with the provisions of the Financial Assistance Policy. The patient and/or guardian must notify HSHS of an approved Financial Assistance Application either verbally or in writing. Upon notification, HSHS may seek verbal or written confirmation of the approved Financial Assistance Application from the Medical Group.
13. Based upon the financial assessment by any HSHS Local System, the Medical Group shall recognize the financial review as a basis for adjusting the Medical Group bills to charity consistent with these provisions of the Financial Assistance Policy. The patient and/or guardian must notify the Medical Group of an approved Financial Assistance Application. Upon notification, the Medical Group may seek verbal or written confirmation of the approved Financial Assistance Application from the Medical Group.



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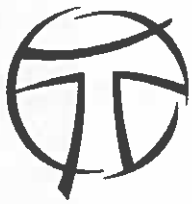
14. HSHS may use external programs to verification patients' ability to pay (e.g. SearchAmerica). If a patient is determined to be unable to pay for their medically necessary services via these external programs, the accounts will be adjusted off to charity.

Guidelines for Determination of 100% Charity Adjustment

1. If an uninsured patient provides proof of a household income level equal to or below 200% of the current year Federal Poverty Guidelines, a 100% charity adjustment will be applied to all HSHS medically necessary services.

Guidelines for Determination of Financial Assistance Discount for the uninsured at HSHS

1. If an uninsured patient presents for medically necessary services, a discount of 25% will be applied to the patient balance at the time of billing.
2. If an uninsured patient's family income level is determined to be above 200% but less than 300% of the current Federal Poverty Guidelines, the patient will receive a reduction of 85% off the HSHS billed charge.
3. If an uninsured patient's family income level is determined to be above 300% but less than 400% of the current Federal Poverty Guidelines, the patient will receive a reduction of 75% off the HSHS billed charge.
4. If an uninsured patient's family income level is determined to be above 400% but less than 500% of the current Federal Poverty Guidelines, the patient will receive a reduction of 65% off the HSHS billed charge.
5. If an uninsured patient's family income level is determined to be above 500% but equal to or less than 600% of the current Federal Poverty Guidelines, the patient will receive a reduction of 55% off the HSHS billed charge.
6. The patient is required to provide proof of income and a completed Financial Assistance Program application in order to obtain this discount.
7. HSHS will consider the following circumstances and other similar circumstances in evaluating applicants who do not otherwise qualify for financial assistance under this policy.
 - a. Catastrophic medical debt defined as medical debt which is more than 25% of the annual income of the patient's family. All HSHS debt in excess of the 25% would be adjusted off to financial assistance upon notice from the patient and verification by HSHS colleagues.
 - b. The time frame calculation for the annual income cap will be based on a 12-month period from the most recent date of medical services.
8. Elective and package price services are not eligible for this discount.
9. This discount will be applied if HSHS receives a validated denial of coverage for medically necessary services.
10. If the patient fails to provide documentation requested or apply for coverage under public programs within 30 days of the hospital's request the application will be denied.



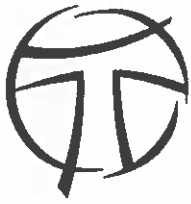
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Guidelines for Determination of Financial Assistance Discount for the insured at HSHS

1. If an insured patient's family income level is determined to be above 200% but less than 300% of the current Federal Poverty Guidelines, the patient will receive a reduction of 85% off the balance due after the account balance becomes the responsibility of the patient.
2. If an insured patient's family income level is determined to be above 300% but less than 400% of the current Federal Poverty Guidelines, the patient will receive a reduction of 75% off the balance due after the account balance becomes the responsibility of the patient.
3. If an insured patient's family income level is determined to be above 400% but less than 500% of the current Federal Poverty Guidelines, the patient will receive a reduction of 65% off the balance due after the account balance becomes the responsibility of the patient.
4. If an insured patient's family income level is determined to be above 500% but equal to or less than 600% of the current Federal Poverty Guidelines, the patient will receive a reduction of 55% off the balance due after the account balance becomes the responsibility of the patient.
5. The patient is required to provide proof of income and a completed Financial Assistance Program application in order to obtain this discount.
6. HSHS will consider the following circumstances and other similar circumstances in evaluating applicants who do not otherwise qualify for financial assistance under this policy.
 - i. Catastrophic medical debt defined as medical debt which is more than 25% of the annual income of the patient's family. All HSHS debt in excess of the 25% would be adjusted off to financial assistance upon notice from the patient and verification by HSHS colleagues.
 - ii. The time frame calculation for the annual income cap will be based on a 12-month period from the most recent date of medical services.
7. Elective and package price services are not eligible for this discount.
8. This discount will be applied if HSHS receives a validated denial of coverage for medically necessary services.
9. If the patient fails to provide documentation requested or apply for coverage under public programs within 30 days of the hospital's request the application will be denied.

Presumptive Eligibility

1. Presumptive eligibility under the Financial Assistance Program may be granted if evidence of a patient's inability to pay for medically necessary services is provided by the patient or through other sources available to HSHS. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual circumstances that may include:
 - a. ALL HOSPITALS (HSHS) AND MEDICAL GROUP:
 - i. Homelessness
 - ii. Deceased with no estate
 - iii. Mental incapacitation with no one to act on patient's behalf
 - iv. Medicaid eligibility, but not on date of service or for non-covered services
 - v. Incarceration in a penal institution



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- vi. Enrollment in the following assistance programs for low-income individuals:
 - 1. Temporary Assistance for Needy Families (TANF)
 - 2. Illinois Housing Development Authority's Rental Housing Support Program
 - 3. Wisconsin Department of Health Services Housing Assistance Program

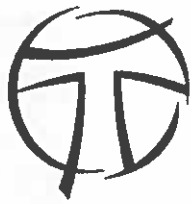
- b. URBAN HOSPITALS – Additional Mandated Categories:
 - i. Enrollment in the following programs with criteria at or below 200% FPL:
 - 1. Participation in Women, Infants and Children programs (WIC);
 - 6. Supplemental Nutrition Assistance Program (SNAP) eligibility;
 - 7. Illinois Free Lunch and Breakfast Program;
 - 8. Wisconsin Free Lunch Program;
 - 9. Low Income Home Energy Assistance Program (LIHEAP);
 - 10. Wisconsin Home Energy Assistance Program (WHEAP);
 - 11. Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria;
 - 12. Receipt of grant assistance for medical services

Asset Exclusion

- 1. HSHS may exclude the following assets listed below from the net available household asset computation without affecting eligibility for the Financial Assistance Program. However, any HSHS entity that is not applying a 25% uninsured patient discount must comply with the requirements in 210 ILCS 89(10)(c)(4)
 - a. A home that is the primary residence
 - b. Personal property for use in the home
 - c. Vehicle(s) up to a combined value \$15,000 with value based on the current blue book appraisal amount (excludes motor homes)
 - d. Liquid assets including cash, savings, stocks, bonds etc. up to \$1,000 for one person; \$2,000 for two people; and \$500 for each additional person in the household;
 - e. Any funds set aside in a retirement account as defined by the Internal Revenue Service;
 - f. Other assets directly related to the earnings and livelihood of the household may be exempt if deemed necessary and reasonable to the continued ability to earn a livelihood by HSHS.

Communication of the Financial Assistance Program to Patients

- 1. Notification about financial assistance availability from HSHS, which shall include the following:
 - a. Financial Assistance Applications: The Financial Assistance application will be provided to patients upon request and throughout the registration and post-registration process. This application will comply with current Illinois and Wisconsin statutes and any applicable federal statutes.
 - b. Posters: The availability of Financial Assistance Program shall be advertised on poster-sized signage located in Admissions, Outpatient, waiting room areas. A toll-free phone number will be included.
 - c. Brochures: Brochures outlining the Financial Assistance Program, application process and toll-free phone number shall be available at all patient registration desks and in all waiting areas.
 - d. Internet: The availability of Financial Assistance Program and Illinois Uninsured Discount Act of 2009 shall be posted on the HSHS Internet home page.
 - e. Patient Statements: Each bill, invoice or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under the HSHS Financial Assistance Program.



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2. Referral of patients may be made by any member of the HSHS staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplain's, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

Financial Assistance Program Determination Notification

1. Once HSHS determines the final balance owed by the patient AND a completed Financial Assistance Program application is received on a patient's account, HSHS will notify the patient, patient's legal guardian, and/or responsible party in writing of the final determination within forty-five (45) calendar days. The notification will include a determination of the amount for which the patient and/or responsible party will be financially accountable. If the application for the Financial Assistance Program is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.

Appeals

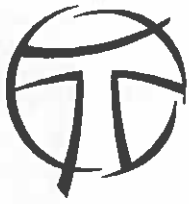
1. The patient and/or responsible party may appeal a denial of eligibility for financial assistance by providing additional information to the Patient Accounts Department within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Patient Accounts Manager and the Chief Financial Officer for a final determination. If the final determination affirms the previous denial of financial assistance, written notification will be sent to patient, legal guardian, and/or responsible party.
2. If an appeal is filed within fourteen (14) calendar days of final determination, any collection efforts will be suspended pending the final outcome of the appeals process.

Reporting Requirements

1. Each Local system should be able to provide the following upon request:
 - a. Financial Assistance Application Form
 - b. Presumptive Eligibility Policy, including each criteria used
 - c. Financial Assistance Statistics (where required by the Illinois Office of the Attorney General)
 - d. Applications submitted (complete and incomplete)
 - e. Applications approved (including number approved using presumptive eligibility)
 - f. Applications denied
 - g. Dollar amount of financial assistance at cost
 - h. Description of electronic and information technology used
2. For Local Systems in Illinois, this information must be submitted to the Illinois Office of Attorney General annually.

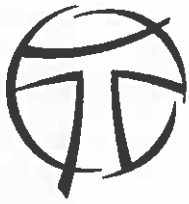
Policy Administration

1. Patients determined to be eligible for the Financial Assistance Program retain eligibility for a period of six (6) months from the date of approval. At the end of six (6) months, the patient is responsible for reapplying for eligibility under the Financial Assistance Program.
2. No collection efforts will be pursued on any account pending approval in the Financial Assistance Program until a final determination is made by HSHS.



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3. Services provided as a result of an accident are subject to all legal instruments required to ensure third party liability payment, even if these instruments are filed after the initial eligibility for the Patient Financial Assistance Program has been approved. If third party coverage exists, HSHS will pursue and collect the balance owed from the third party payer.
4. Each HSHS Local System will use a reputable external bad debt collection agency and/or attorney for processing bad debt accounts.
 - a. Accounts assigned to an external bad debt collection agency or attorney for more than one year from the date of medical services will not be eligible for financial assistance. HSHS will consider exceptions to this provision of the policy on a case by case basis. Only the Director of Patient Financial Services, System Vice President of Revenue Cycle or the Chief Financial Officer in the Local System or the Division has the authority to grant exceptions.
 - b. Any collection attorneys working on behalf of HSHS are NOT authorized to attach bank accounts and in no case file body attachments.
 - c. Any lien placed on a patient's real estate property must be authorized in writing from the Division President or delegate.
 - d. Collection attorneys must follow HSHS's value-based procedures in the pursuit of estates, garnishments and judgments for non-payment of medical debts.
5. Application can be made on behalf of the patient by a concerned party, including but not limited to:
 - a. Patient or guarantor
 - b. Faith community leader or representative
 - c. Physician or other health care professionals
 - d. Member of the Administration
6. This policy shall be supervised by the Patient Accounts Manager (or another colleague designated by the Local System CFO, Division CFO or System Vice President of Revenue Cycle) who shall be responsible for administering the program, assuring that determination for financial assistance meets the requirements of this policy, and notifying the patient and/or responsible party of the final determination. Any application from family members, friends or associates should be referred to the Director of Patient Financial Services or similar position at HSHS or Medical Group. The following MINIMUM approval authority is granted per this policy:
 - a. \$0 to \$5,000 – Manager of Patient Accounts and Coordinators
 - b. \$5,001 to \$25,000 – Director of Patient Financial Services
 - c. \$25,001 to \$100,000 – HSHS Director of Finance, Vice President or Chief Financial Officer;
 - d. >\$100,000 – Chief Executive Officer of Local System, HSHS or delegate
7. Other circumstances may compellingly show that full payment of outstanding medical expenses could cause serious social and/or financial hardship to the patient or the household. These circumstances may warrant an exceptional financial assistance reduction to be considered on a case by case basis.
8. The preceding guidelines are set forth in establishing the Financial Assistance Program. HSHS may modify these guidelines at any time consistent with existing law. HSHS reserves the right to approve or deny a financial assistance application received at its discretion. In implementing this Policy, HSHS management shall comply with all other federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to this Policy.



Hospital Sisters
HEALTH SYSTEM

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Originator: Richard Walbert
Vice President, Finance

Accountable Leader: Michael Cottrell
Chief Financial Officer

Administrative Approval: Mary Starmann-Harrison
President & CEO



Hospital Sisters
HEALTH SYSTEM

FINANCIAL ASSISTANCE APPLICATION

Belleville, IL
HSBS St. Elizabeth's Hospital

Breese, IL
HSBS St. Joseph's Hospital

Decatur, IL
HSBS St. Mary's Hospital

Effingham, IL
HSBS St. Anthony's Memorial Hospital

Highland, IL
HSBS St. Joseph's Hospital

Litchfield, IL
HSBS St. Francis Hospital

Springfield, IL
HSBS St. John's Hospital

Streator, IL
HSBS St. Mary's Hospital

Chippewa Falls, WI
HSBS St. Joseph's Hospital

Eau Claire, WI
HSBS Sacred Heart Hospital

Green Bay, WI
HSBS St. Mary's Hospital Medical Center
HSBS St. Vincent Hospital

Oconto Falls, WI
HSBS St. Clare Memorial Hospital

Sheboygan, WI
HSBS St. Nicholas Hospital

HSBS Medical Group
Prairie Cardiovascular

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE

Completing this application will help Hospital Sisters Health System determine if you can receive free or discounted services or other public programs that can help pay for your health care. 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, 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.

CERTIFICATION STATEMENT

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 in this application may be verified to ensure accuracy. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, and financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient or
Applicant
Signature: _____
Date: _____

www.hshs.org

*Sponsored by the
Hospital Sisters
of St. Francis*

FINANCIAL ASSISTANCE PROGRAM

Please provide copies of the following items:

- W-2 withholding statements
- Most recent federal/state income tax forms
- Paycheck/Unemployment check stubs (past 3 months) or written statement of earnings from your employer (past 3 months).
- Forms approving or denying Unemployment, Workers Compensation or Assistance from the Department of Public Aid
- Statement of annual benefits from Social Security
- Checking/savings account statements (past 3 months)
- Other: letter explaining your situation

Your cooperation with Hospital Sisters Health System (HSHS) is extremely important in determining your eligibility for financial assistance. Failure to provide this information will be cause to deny financial assistance.

Please return completed application along with required documentation to the hospital where you received your medical care:

WISCONSIN

EASTERN WISCONSIN

St. Mary's Hospital – Green Bay, WI
 St. Vincent Hospital – Green Bay, WI
 St. Nicholas Hospital – Sheboygan, WI
 St. Clare Memorial Hospital – Oconto Falls, WI

All **Eastern Wisconsin** completed applications along with all attachments should be sent to the following address:

Patient Financial Services
 Attention: Financial Assistance Program
 PO Box 13508
 Green Bay, WI 54307

Local - (920) 433-8122
 Toll free - (800) 211-2209
 Fax - (920) 431-3161

WESTERN WISCONSIN

St. Joseph's Hospital – Chippewa Falls, WI
 Sacred Heart Hospital - Eau Claire, WI

All **Western Wisconsin** completed applications along with all attachments should be sent to the following address:

Patient Financial Services
 Attention: Financial Assistance Program
 900 West Clairemont Avenue
 Eau Claire, WI 54701

Local - (715) 717-4141
 Toll free - (888) 445-4554
 Fax - (715) 717-4032

ILLINOIS

CENTRAL ILLINOIS

St. John's Hospital – Springfield, IL
 St. Francis' Hospital – Litchfield, IL
 St. Mary's Hospital – Decatur, IL
 St. Mary's Hospital – Streator, IL

All **Central Illinois** completed applications along with all attachments should be sent to the following address:

Patient Accounts Department
 Attention: Financial Assistance Program
 2343 South MacArthur Blvd.
 Springfield, Illinois 62704

Local - (217) 525-5615
 Toll free - (888) 477-4221

SOUTHERN ILLINOIS

St. Elizabeth's Hospital – Belleville, IL
 St. Joseph's Hospital – Highland, IL
 St. Anthony's Hospital – Effingham, IL
 St. Joseph's Hospital – Breese, IL

All **Southern Illinois** completed applications along with all attachments should be sent to the following address:

Patient Accounts Department
 Attention: Financial Assistance Program
 211 South Third Street
 Belleville, IL 62220

Local - (618) 234-8600

FINANCIAL ASSISTANCE APPLICATION

APPLICANT/RESPONSIBLE PARTY INFORMATION

APPLICANT NAME (last, first, middle initial) _____

BIRTHDATE: _____

SOCIAL SECURITY NUMBER: _____

PHONE NUMBER: _____

HOME ADDRESS (City, State, Zip) _____

PREVIOUS ADDRESS (City, State, Zip) _____

Members of family unit	HOUSEHOLD MEMBER NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT <i>If Applicant Self</i>	Live at home		SOCIAL SECURITY NUMBER	Current Patient?	
				Yes	No		Yes	No
1.								
2.								
3.								
4.								
5.								

PRESUMPTIVE ELIGIBILITY CRITERIA:

Does any of the information below apply to you? If YES, check all that apply Please provide documentation/verification if you check YES to any of the statements below:

- | | |
|--|--|
| <input type="checkbox"/> Homelessness
<input type="checkbox"/> Deceased with no estate
<input type="checkbox"/> Mental incapacitation with no one to act on patient's behalf
<input type="checkbox"/> Medicaid eligibility, but not on date of services or for non-covered service
<input type="checkbox"/> Incarceration in penal institution | <input type="checkbox"/> Enrolled in Temporary Assistance for Needy Families (TANF)
<input type="checkbox"/> Enrolled in Illinois Housing Development Authority's Rental Housing Support Program
<input type="checkbox"/> Enrolled in Wisconsin Department of Health Services Housing Assistance Program |
|--|--|

Enrollment in the following assistance for low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:

- | | |
|--|--|
| <input type="checkbox"/> Woman, Infant and Children Nutrition Program (WIC)
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)
<input type="checkbox"/> Illinois Free Lunch and Breakfast Program
<input type="checkbox"/> Wisconsin Free Lunch Program
<input type="checkbox"/> Low Income Home Energy Assistance Program (LIHEAP) | <input type="checkbox"/> Wisconsin Home Energy Assistance Program (WHEAP)
<input type="checkbox"/> Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria
<input type="checkbox"/> Receipt of grant assistance for medical services |
|--|--|

If you checked YES to any of the above, please stop and send this application and supporting documentation to the appropriate address as shown on page 2.

Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veteran's benefits, Medicaid and/or Medicare? If yes, please provide the following information:

Policy holder: _____

Insurer: _____ Policy Number: _____

Were you covered or eligible under a spouse/ partner or former spouse/partner's health insurance policy, foreign coverage policy, Health Insurance Marketplace policy, Veteran's benefits, Medicaid and/or Medicare policy for any or all of your medical service?

Former Spouse/partner name: _____ Phone number: _____

Former spouse/partner address: _____

EMPLOYMENT 1 HOUSEHOLD MEMBER	EMPLOYER'S NAME	EMPLOYER'S ADDRESS (City, State, Zip)
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SALARY (GROSS): (AMOUNT)	PERIOD: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> TWICE A MONTH <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	HOW LONG: YR _____ MO _____	POSITION:
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EMPLOYMENT 2 HOUSEHOLD MEMBER	EMPLOYER'S NAME	EMPLOYER'S ADDRESS (City, State, Zip)
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SALARY (GROSS): (AMOUNT)	PERIOD: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> TWICE A MONTH <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	HOW LONG: YR _____ MO _____	POSITION:
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UNEARNED INCOME Child support does not need be revealed if you do not wish to have it considered as a basis for repaying this obligation.	TYPE OF UNEARNED INCOME	HOUSEHOLD MEMBER	AMOUNT	PERIOD	
	1.				
	2.				
	3.				
	4.				
	5.				

CHILD SUPPORT NAME OF CHILD (RECEIVING)	NAME OF PERSON / PARENT PAYING	AMOUNT	PERIOD
1.			
2.			

HOME: <input type="checkbox"/> Rent <input type="checkbox"/> Own	NAME AND ADDRESS OF LANDLORD	RENT PMT	DUE DATE	CONTRACT PMT	MORTGAGE PMT
		PURCHASE PRICE	DATE PURCHASE	BALANCE DUE	ESTIMATED VALUE

ASSETS/RESOURCES Assets that are counted include: cash, checking and savings accounts, recreational vehicles, real estate other than the home or land you live on, a life insurance policy with a cash surrender value, stocks and bonds.	TYPE OF ASSET	HOUSEHOLD MEMBER	AMOUNT	PERIOD	BANK/ DESCRIPTION	

CREDIT/RECURRING ACCOUNTS	WHAT WAS PURCHASED	AMOUNT FINANCED	UNPAID BALANCE	MONTHLY PAYMENT
NAME AND ADDRESS OF CREDITOR				
1.				
2.				
3.				

CHILD SUPPORT EXPENSES	CHILD NAME	AMOUNT	PERIOD
HOUSEHOLD MEMBER MAKING PAYMENT			
1.			
2.			

Are you seeking financial assistance for treatment related to: Workplace injury Accident Crime Cancer
 If yes, please provide details:



Hospital Sisters
HEALTH SYSTEM

Financial Assistance Program

In order to complete an application for financial assistance at Hospital Sisters Health System we need the item(s) that are checked below.

If you have questions, please contact us at the telephone number listed below. Your cooperation is appreciated.

_____ W-2 withholding statements

_____ Most recent federal/state income tax forms

_____ Paycheck/Unemployment check stubs (past 3 months) or written statement of earnings from your employer (past 3 months).

_____ Forms approving or denying Unemployment, Workers Compensation or Assistance from the Department of Public Aid

_____ Statement of annual benefits from Social Security

_____ Checking/savings account statements (past 3 months)

_____ Letter explaining your situation

_____ Other: _____

_____ Other: _____

_____ Other: _____

HSBS Central Illinois Division Patient Financial Services

Springfield, Decatur, Litchfield, Streator

(217) 525-5615 or toll-free (888) 477-4221