ROCKFORD HEALTH system
Respectful Care

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

4/09

ROCKFORD HEALTH system
Respectful Care

Date ______________________________
RHS Representative ________________
Patient Account No.________________

FINANCIAL DISCLOSURE SHEET
UNINSURED

As part of our commitment to our community, Rockford Memorial Hospital provides financial assistance to individuals with limited financial resources who meet established eligibility criteria. This Financial Assistance Application will gather information about you and all other members of your household that will help us make an appropriate determination of your eligibility for financial assistance. In accordance to the Illinois Hospital Uninsured Patient Discount Act, we need to accurately assess your payment ability by providing copies of your most recent IRS 1040 Income Tax Return; W2s (including all schedules); the last two paycheck stubs for all working household members; and copies of patient statements for Rockford Memorial Hospital balances. We have enclosed a postage paid return envelope for your convenience.

Please return by__________________________

Patient Name: ____________________________________ Social Security No.____________________
Birthdate: ____ Phone Number: ________________________
Guarantor Name: __________________________________ Social Security No.____________________
Birthdate: ____ Phone Number: ________________________
Address: ____
Number City State Zip

Employer: ____ Years Employed: ________
Employer's Address/Phone____
Number City State Zip Phone

Spouse's Name: ___________________________________Social Security No.______________________
Birthdate: ____ Phone Number:________________________
Spouse's Employer:____
Employer's Address/Phone ____
Number City State Zip Phone

Checking Account(s)

Name on Account	Number	Bank	Current Balance
___________________	____________	_________________	$______________________
___________________	____________	_________________	$______________________

Savings Account(s)

Name on Account	Number	Bank	Current Balance
___________________	____________	_________________	$______________________
___________________	____________	_________________	$______________________

Credit Card(s)

Credit Card Name	Credit Limit	Current Balance	Monthly Payment
_________________	$ _____________	$______________	$______________________
_________________	$_____________	$______________	$______________________
_________________	$_____________	$______________	$______________________
			Total $______________________

OVER

Net Income	**Per Month**	**Additional Income**	**Value/Balance**	**Contribution**
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: _________

NAME	AGE	RELATIONSHIP
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.