

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES INSURED

Rockford Health System provides health care 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.

Patients residing within the RHS service area may receive services without charge or at a discounted charge and must demonstrate that they can not afford to pay for full charges. Patients who reside outside of the RHS service area will generally not be eligible for financial assistance consideration. These patients should be encouraged to seek treatment at an appropriate facility located within their geographic proximity. Exceptions may be made for those services in which RHS is a recognized referral center.

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.)

ELIGIBILITY CRITERIA

The determination as to whether the patient meets the established criteria for financial assistance should be made as early as possible (before or at the time of service is preferable). 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 RHS application will be considered.** A denial from Public Aid for failure to cooperate will result in a denial from RHS. Federal Poverty Guidelines will be used to help determine eligibility.

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

1. Persons eligible should have an established address in the RHS community.
2. Financial assistance will be given based on gross family income for the past 12 months (or last 3 months x 4).
Gross income must be verified using the following documentation:
 - a. check pay stubs or unemployment check stubs
 - b. statements of monthly social security benefits
 - c. prior year's Income Tax Return
 - d. most recent checking and savings account bank statement
3. Failure to provide the above information could disqualify you from any consideration.

Guidelines – continued:

4. Employment status – current and future.
5. Family size (according to what is reported on Income Tax Return)
6. Outstanding financial obligations, with special consideration to other medical obligations.
7. Review of credit bureau report to verify outstanding financial obligations.
8. Amounts already paid will not be considered for financial assistance or eligible for refund.
9. Financial assistance will not be considered until all third party payors have been billed and payments have been received or denied. This may include a State Medicaid and Social Security application being processed.
10. Accounts previously referred to outside collection agencies will not be considered eligible.
11. Extenuating circumstances – major issues and/or problems that may contribute to an inability to pay, such as extended major illness (catastrophic) should be described and attached to the Financial Disclosure Sheet.
12. Cooperation from the patient/guarantor throughout the process is required.

INCOME GUIDELINES

Size of Family Unit	2009 Federal Poverty Guidelines	Tiers I: 175% or less of Federal Poverty Guidelines	Tiers II: 176 - 200% of Federal Poverty Guidelines	Tiers III: 201 - 225% of Federal Poverty Guidelines	Tiers IV: 226 - 250% of Federal Poverty Guidelines	Tiers V: 251 - 275% of Federal Poverty Guidelines	Tiers VI: 276 - 300% of Federal Poverty Guidelines
1	10,830	18,953	\$21,660	\$24,368	\$27,075	\$29,783	\$32,490
2	14,570	25,498	\$29,140	\$32,783	\$36,425	\$40,068	\$43,710
3	18,310	32,043	\$36,620	\$41,198	\$45,775	\$50,353	\$54,930
4	22,050	38,588	\$44,100	\$49,613	\$55,125	\$60,638	\$66,150
5	25,790	45,133	\$51,580	\$58,028	\$64,475	\$70,923	\$77,370
6	29,530	51,678	\$59,060	\$66,443	\$73,825	\$81,208	\$88,590
7	33,270	58,223	\$66,540	\$74,858	\$83,175	\$91,493	\$99,810
8	37,010	64,768	\$74,020	\$83,273	\$92,525	\$101,778	\$111,103
Eligible Basic Financial Assistance Allowance		100%	80%	60%	40%	20%	10%

For Families with more than eight members, add \$3,740 for each additional member to arrive at the applicable Federal Poverty Guideline.

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**



Respectful Care

Date _____
RHS Representative _____
Patient Account No. _____

FINANCIAL DISCLOSURE SHEET
INSURED

As part of our commitment to our community, Rockford Health System 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 order to accurately assess your payment ability, we ask that you provide us with 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 healthcare balances owed to Rockford Health System or other providers. We have enclosed a 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
\$ _____
\$ _____

Number City State Zip Phone
Savings Account(s)
Name on Account Number Bank Current Balance
\$ _____
\$ _____

Credit Card(s)
Credit Card Name Credit Limit Current Balance Monthly Payment
\$ _____ \$ _____ \$ _____
\$ _____ \$ _____ \$ _____
\$ _____ \$ _____ \$ _____
Total \$ _____

OVER

<u>Net Income</u>	<u>Per Month</u>	<u>Additional Income</u>	<u>Value/Balance</u>	<u>Contribution</u>
Guarantor	\$ _____	IR 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. _____	_____	_____

<u>Expenses:</u>	<u>Per Month</u>
Rent/Mortgage	\$ _____
Home Equity Value \$ _____	\$ _____

<u>Car(s)</u>	<u>Make</u>	<u>Year</u>	<u>Model</u>	<u>Per Month</u>
_____				\$ _____
_____				\$ _____
Food				\$ _____
Gasoline for Transportation				\$ _____
• Heat				\$ _____
• Electric				\$ _____
• Telephone/Cell				\$ _____
• Auto Insurance				\$ _____
• Cable				\$ _____

<u>Other Expenses:</u> (Please List)	<u>Per Month</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____

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 Health System to obtain a personal credit bureau report to verify outstanding financial obligations.