PLAIN LANGUAGE SUMMARY

Sarah Bush Lincoln Fayette County Hospital offers several financial assistance programs to help uninsured and underinsured patients with bills for medically necessary services. We provide emergency medical care to everyone. All patients receiving medically necessary services may apply for financial assistance . Eligible patients will have their care partially or fully covered. Any balance in excess of the lowest calculated financial responsibility under our various programs will be covered. Eligible patients will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care.

FINANCIAL ASSITANCE PROGRAMS

A fully completed Financial Assistance Application and proof of income documents are required to apply for the following programs:

1. **Family Income Test:** The financial obligation is calculated as 15% of the Family Income in excess of 190% of Federal Poverty Guidelines (FPG) for a period of four years. All charges in excess of this amount are covered as a charitable discount. All insurance benefits must be exhausted to qualify.

2. **Discount Test:** Family Income and Family Size are compared to the FPG to determine financial responsibility under a sliding fee scale. Family Income below 190% of the FPG qualifies for a 100% charity discount. For each increment of income up to 400% of the FPG, the discount decreases by 10%. All insurance benefits must be exhausted to quality.

3. **IL Uninsured Patient Discount/Adjusted to Cost Test:** This program is available only to uninsured Illinois residents. Proof of residency is required. Family Income less than 190% of FPG qualifies for a 100% charity discount. Family Income between 190% and 400% of the FPG qualifies for a discount equal to the Illinois Uninsured Discount Factor determined using the Medicare cost report.

Presumptive Charity: No Financial Assistance Application is required. A 100% charity discount is applied when there are no insurance benefits and the patient satisfies one of the established categories of presumptive financial need.

How to obtain Application Form: The Sarah Bush Lincoln Fayette County Hospital Financial Assistance Application form may be obtained free of charge.

- See reverse side of this application
- They are available at the Hospital main registration desk or in the Financial Assistance Counselors office, and at the main registration desk of any Hospital-owned clinics.
- Call Sarah Bush Lincoln Fayette County Hospital Financial Counselor at 618-283-5140 to have an application mailed to you.
- Write to Sarah Bush Lincoln Fayette County Hospital, 650 W. Taylor Street, Vandalia, IL 62471 and have an application mailed to you.
- Download the application from our website: **www.sblfch.org**

Application Process: Mail completed applications (with all documentation and information specified in the application instructions) to Sarah Bush Lincoln Fayette County Hospital, 650 W. Taylor Street, Vandalia, IL 62471.

Our Financial Assistance Counselor is available to assist you in completion of the application Monday through Friday, 8:00am to 4:00m at the Hospital.

This Summary, the Financial Assistance Policy, and the application form are available in Spanish upon request.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reprot5ed to the Health Care Bureau of the Illinois Attorney General at 1-877-305-5145 (TTY 1-800-364-3013). The Health Care Bureau website can be located at www.illinoisattorneygeneral.gov.

Revised 03/01/2023

Sarah Bush Lincoln Fayette County Hospital

Financial Assistance Program

Enhanced to better serve people with greater financial needs.

Have billing questions or in need of further assistance?

Financial Assistance Counselor
Phone: 618-283-5140
Fax: 618-283-3778
Monday—Friday
8:00am to 4:00pm

Sarah Bush Lincoln
Fayette County Hospital

Trusted Compassionate Care

www.sblfch.org

Sarah Bush Lincoln Fayette County Hospital

Financial Assistance Program

Important:

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Sarah Bush Lincoln Fayette County Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to Sarah Bush Lincoln Fayette County Hospital Financial Counselor in person or by mail to apply for free or discounted care within 240 days following the date the first billing statement was mailed to the patient.

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.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist Sarah Bush Lincoln Fayette County Hospital in determining whether the patient is eligible for financial assistance.

We will work with community members to help simplify the business aspect of our relationship. For example, we will help patient's obtain payment from third parties such as Medicaid and Medicare by answering their questions and assisting them with applications. We offer financial assistance for persons who meet the financial terms once they've submitted the necessary paperwork. We invite patients to apply for financial assistance when they cannot cover account balances after we've received payments from third-party payers (like Medicaid, Medicare and insurance companies).

This form must be received by SBL Fayette County Hospital within 240 days following the date the first billing statement is mailed to the patient.

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The mission of Sarah Bush Lincoln Fayette County Hospital is to provide exceptional care to all and create healthy communities.

APPLICATION for SBL-FCH FINANCIAL ASSISTANCE

If you need help with this form, please call 618-283-5140.

APPLICANT INFORMATION

Name_____

Date of Birth_____

Address_____

_____

Social Security#_____
(not required if you are uninsured)

Telephone or cell phone number_____

OPTIONAL INFORMATION

Race_____

Ethnicity_____

Sex_____

Preferred Language_____

Providing this information will not have any impact on the outcome of your application.

FAMILY/HOUSEHOLD INFORMATION

Name_____**Birthdate**_____

Name_____**Birthdate**_____

Name_____**Birthdate**_____

Name_____**Birthdate**_____

Name_____**Birthdate**_____

Name_____**Birthdate**_____

PATIENT'S EMPLOYMENT INFORMATION

Patient's Employer Name_____

Patient Employer Address_____

Guarantor/Spouse/Partner Employer Name

_____

Guarantor/Spouse/Partner Employer Address

_____

INSURANCE INFORMATION

- ☐ **Health Insurance Name**_____
- ☐ **Medicare**
- ☐ **Medicare Supplement Name**_____
- ☐ **Medicaid**

CERTIFICATION

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.

_____
Applicant's Signature

_____
Signature Date

To apply for the IL Hospital Uninsured Discount, proof of residency and one of the following proof of income documents is required: recent tax return; W-2 or 1099; two most recent pay stubs; written verification from employer; or one other reasonable form of income verification.

Copies of the following forms must be submitted with your application (if applicable) to apply for all other financial assistance programs:

- ☐ Most recent bank statements.
- ☐ Most recent tax forms. Last two years for those who are self employed.
- ☐ Most recent check stub (s) from all jobs.
- ☐ Unemployment check stub listing start date and amount.
- ☐ Divorce decree stating child support paid or alimony & child support received.
- ☐ Letter from public program (Social Security, Veterans, Public Aid) listing amount received.
- ☐ Verification of all other income.
- ☐ Public Aid approval or denial letter if applicable– pregnant, dependent children, disable, blind, over age 65.

Sarah Bush Lincoln Fayette County Hospital will make such a determination based upon a review of some or all of the following information:

- Verification of household income.
- Checking and Savings account information.
- Investments—CD's, stocks, bonds, retirement accounts.
- Property—home ownership, rental property.
- Vehicles—boats, RV's & 4-wheelers.
- Other significant assets.