KSB HOSPITAL
KATHERINE SHAW BETHEA HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

Approval/Denial Process

1. **All patients (Insured, Self-Pay, Medicare) must apply for Illinois Medicaid prior to submitting a KSB Financial Assistance Application**, then provide detailed documents of why you were approved or why you were denied (being denied for not compliant/or missing documents will not be accepted). Please note this process could take 90+ days.

2. KSB will permit an Uninsured patient to apply for a discount within 240 days after date of first statement for any services rendered at KSB by KSB providers. If no application is received within 240 days after the date of service, the account may not be eligible for Financial Assistance.

3. Once Step #1 has been completed, please provide the following required documents listed on page 2, along with your signed, dated and completed KSB Financial Assistance Application on pages 4 and 5. If a document is missing, or more information is being requested, a letter will be mailed to the patient explaining what is needed.

4. When all documents are received, each application is evaluated individually on a sliding income based scale as outlined on page 3 of this packet.

5. After a committee approval or denial decision is made based on our policy and documents received from each patient, a letter will be mailed to the patient explaining what accounts were covered and at what percent (0%, 25%,50%,100%) as well as what will be patient responsibility.

Services Not Covered by Financial Assistance Program

The following list of services and items that are not covered under KSB Hospital's Financial Assistance Program. Examples include, but are not limited to the following:

- Vasectomies
- Tubal Ligations
- Accounts that insurance needs information from the member.
- Glasses/Contacts
- Hearing Aids
- Orthopedic Shoe Inserts
- Contraceptive Procedures
- Fertility Studies
- Cardiac Rehab Phase 3
- Pulmonary Rehab Phase 3
- All Sleep Study Readings (readings are performed by a non-KSB billed Physician).
- Venous Ablation

Please contact the KSB Financial Advocate with any questions Monday through Friday, 8:00 a.m. to 4:30 p.m., at (815) 284-5714, by email at financialadvocate@ksbhospital.com or visit https://www.ksbhospital.com/financialassistance/.

Lovett Center, 101 W 1st Street, Dixon, Illinois 61021

KSB HOSPITAL
KATHERINE SHAW BETHEA HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

Financial Assistance Application
Required Documents

Be sure to include copies of income information along with your signed, dated and completed financial assistance application. We must have this information for our process of review. We will need:

- ☐ Illinois Public Aid approval/denial documents (this is required for all Medicare, self-pay & insured patients). SNAP approval/denial documents will NOT fulfill this requirement, must be MEDICAL CARD approval/denial documents.
- ☐ Proof of Illinois residency (State ID, Voter/Vehicle Registration Card, recent residential utility bill).
- ☐ Copy of most recent complete Federal 1040 Income Tax Return (Include all Schedules and Forms. Copies are available at www.irs.gov).
- ☐ Copy of most recent Federal 1040 Income Tax return of person that claimed you as a dependent (Include all Schedules and Forms).
- ☐ Copy of most recent W-2 documents and 1099 forms.
- ☐ Copies of last two paycheck stubs (or written documentation from employer).
- ☐ Copy of most recent (last 30 days of activity) bank statements (Include Personal and Business Checking and Savings).
- ☐ Copy of any other income such as Social Security, Unemployment, Worker's Compensation, Long-term or Short-term Disability, Pension, 401(k) Plan, Rental Property, Investments, Child Support, etc.
- ☐ Copy of Final Divorce Decree/Dissolution of Marriage (if applicable).
- ☐ Letter with contact information from person helping and supporting you financially.

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FINANCIAL ASSISTANCE PROGRAM

2018 Annual Income Guidelines
for Uncompensated Care Eligibility Determination

Effective January 22, 2018

Family Size	Income Level: Poverty Guidelines	200%	250%	300%	350%
1	$ 12,140	$ 24,280	$ 30,350	$ 36,420	$ 42,490
2	$ 16,460	$ 32,920	$ 41,150	$ 49,380	$ 57,610
3	$ 20,780	$ 41,560	$ 51,950	$ 62,340	$ 72,730
4	$ 25,100	$ 50,200	$ 62,750	$ 75,300	$ 87,850
5	$ 29,420	$ 58,840	$ 73,550	$ 88,260	$ 102,970
6	$ 33,740	$ 67,480	$ 84,350	$ 101,220	$ 118,090
7	$ 38,060	$ 76,120	$ 95,150	$ 114,180	$ 133,210
8	$ 42,380	$ 84,760	$105,950	$ 127,140	$ 148,330
*	$ 4,320	$ 8,640	$ 10,800	$ 12,960	$ 15,120

(*) For family units over eight (8), add the amount shown for each additional member.

Source: Department of Health and Human Services - Federal Poverty Guidelines

FPL Range	Additional Discount
< = 200%	100%
>200% and < = 250%	75%
>250% and < = 300%	50%
301% and higher	0%

Lovett Center, 101 W 1st Street, Dixon, Illinois 61021

KSB HOSPITAL
KATHERINE SHAW BETHEA HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

Financial Assistance Application – Page 1

(Please print or type)

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 situation, **please provide us with copies of the following: Illinois Public Aid approval/denial documents, proof of Illinois residency, the most recent IRS 1040 Income Tax Return (including all schedules), W-2 and 1099 forms for the patient and/or anyone providing financial support to the patient, last two paycheck stubs for all working household members, most current and complete bank statements, and any other income such as Social Security, Unemployment, Pension, 401(k) Plan, Rental Property, Investments, Child Support, etc. If applicable, Final Divorce Decree/Dissolution of Marriage is also requested.**

Applicant Name: _____ Phone #: _____

Address: _____
Street City State/Zip

Social Security #: _____ Date of Birth: _____

Applicant's Employer/Address/Phone: _____

Years there: _____ Approx. Gross Income: $ _____ (weekly, bi-weekly, monthly)

When care was provided:
1) Were you an Illinois resident? Yes or No
2) Involved in an accident? Yes or No
3) Involved in a crime? Yes or No

Spouse's Name: _____ Spouse's Phone #: _____

Spouse's Employer/Address/Phone: _____

Years there: _____ Approx. Gross Income: $ _____ (weekly, bi-weekly, monthly)

If divorced, is former spouse responsible for healthcare costs? Yes or No

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Name on Checking Account(s)	Bank	Current Balance
_____	_____	$_____
_____	_____	$_____

Name on Savings Account(s)	Bank	Current Balance
_____	_____	$_____
_____	_____	$_____

	Additional Income/Assets	Monthly Balance	Monthly Income
CD	$_____	$_____	$_____
Credit Union	$_____	$_____	$_____
Stocks/Bonds	$_____	$_____	$_____
HSA	$_____	$_____	$_____

Additional Assets:

Vehicle(s)
Year/Make/Model: _____
Year/Make/Model: _____

Other Real Property
Address/Value: _____
Address/Value: _____

KATHERINE SHAW BETHEA HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

Financial Assistance Application – Page 2

(Please print or type)

Please list name, age, and relationship of all dependents. (Exclude yourself)

Name	Age	Relationship	Name	Age	Relationship
1.			2.		
3.			4.		

Please give a brief description of your current financial situation. If you are receiving financial support from another individual, please provide a signed letter from them. This should include their name, phone number and mailing address. (This information will remain confidential.)

_____

_____

_____

_____

_____

By signing below, you certify on behalf of yourself and your household to Katherine Shaw Bethea Hospital, and authorize KSB Hospital to proceed as follows:

1. The information provided on this Application is true, accurate and complete to the best of my knowledge;
2. KSB Hospital may obtain a personal credit bureau report to verify outstanding financial obligations;
3. KSB Hospital has the right to verify all information provided with this application, including through 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 Katherine Shaw Bethea Hospital; or, we have provided all relevant information regarding our insurance to Katherine Shaw Bethea Hospital.

_____ _____

Applicant Signature Date

_____ _____

Spouse Signature Date

Please mail or return application and all required documents to:

Financial Advocate
KSB Lovett Center
101 W. First Street, Dixon, IL 61021
Phone: 815-284-5714 Fax: 815-285-5688
financialadvocate@ksbhospital.com

For Hospital Use Only

Date Application Received: _____ Received By: _____

Hospital Balance: _____Collection Balance: _____Total$: _____

Approved: _____Denied: _____Date: _____