KSB PATIENT FINANCIAL SERVICES
KATHERINE SHAW BETHEA HOSPITAL

Date: _____

Mr(s):_____

The following documentation is required in order to apply for Financial Assistance with Katherine Shaw Bethea Hospital. Please return all documents that apply to you to the address below within the next 30 days so that we may determine your eligibility. Patients have 120 days from date of service to apply for example, if you the patient are applying at 100 days after date of service you will have 20 days to get us all information required to be eligible.

- ***The KSB Financial Assistance policy is focused on serving uninsured patients. Those with active health insurance are not eligible to apply.***
- **Identification with current proof of residency within the state of Illinois**
  (Driver's license, State ID, Lease agreement, mortgage statement or utility bill)
- **The balance is over $500.00 and is not a co-pay, collection account, or deductible fee**
- **Proof of income from all working persons in the household:**
  A complete copy of your most recent year's income tax returns with W2.
  Unemployment benefit checks (If recently unemployed)
  Last 2 check stubs *(patient and spouse if applicable)*
  Social Security benefits letter (If applicable)
- **Letter of support (preferably notarized) if not employed.**
- **Proof of dependents.** *(if not listed on tax forms)*
  (Birth Certificate, Social Security card or Identification)
- ***Additional documentation may be required upon application review.***

If you have any questions, please feel free to contact us at (815) 284-5714 Monday- Friday.

PLEASE MAIL ALL THE DOCUMENTATION TO:
KATHERINE SHAW BETHEA HOSPITAL
403 E 1ST STREET
DIXON, IL 61021
ATTN: FINANCIAL COUNSELOR
SUBMIT VIA FAX TO (815) 285-5688
SUBMIT VIA EMAIL TO FINANCIALCOUNSELOR@KSBHOSPITAL.COM

Financial Assistance Application
Approval/denial Process

1. All patients (Self-Pay) must apply for Illinois Medicaid by completing a Great Lakes Medicaid Inc. authorization then submitting it to KSB along with your 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. Once Step #1 has been completed, please provide the following documents listed on the next page, along with your KSB Financial Assistance Application. If a document is missing, or more information is being requested, a letter will be mailed to the patient explaining what is needed.

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

4. 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%, 50%,75%,100%) as well as what will be patient responsibility.

Not Covered by Financial Assistance

The following list of services and items that are not covered under KSB Hospital's Financial Assistance Program.

- Copays
- Deductible
- Balances <$500.00
- Any balance that has been placed in collections (Bad Debt)
- 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

***Please note that additional charges may apply if your physician changes the ordered services. This excludes durable medical equipment, physician, surgeon, anesthesiologist, pathologist, and radiology services. These fees are billed separately by their respective billing agents and are not covered by any discount offer or estimate. Examples of these agencies includes: Rockford Anesthesiologists Associated, Rockford Radiology Associates, Miller Eye Center and others.**

Any questions, please contact the Financial Counselor at (815) 284-5714.

KSB PATIENT FINANCIAL SERVICES
KATHERINE SHAW BETHEA HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

2020 Annual Income Guidelines
Uncompensated Care Eligibility Determination
Effective January 15, 2020

Family Size	Poverty Guidelines	200%	250%	300%	350%
1	$12,760	$25,520	$31,900	$38,280	$44,660
2	$17,240	$34,480	$43,100	$51,720	$60,340
3	$21,720	$43,440	$54,300	$65,160	$76,020
4	$26,200	$52,400	$65,500	$78,600	$91,700
5	$30,680	$61,360	$76,700	$92,040	$107,380
6	$35,160	$70,320	$87,900	$105,480	$123,060
7	$39,640	$79,280	$99,100	$118,920	$138,740
8	$44,120	$88,240	$110,300	$132,360	$154,420
*	$4,480	$8,960	$11,200	$13,440	$15,680

(*) 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%

Katherine Shaw Bethea Hospital

Financial assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help KSB 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 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 quality for any public programs.

Please complete this form and submit it to the hospital in person, by mail, email, or fax to apply for free or discounted case within 30 days. ***You will receive a final determination letter via mail within 30 days upon receipt of all required documents.***

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.

Internal Use Only:

Application Date: _____ MRN:_____ Account Balance: $ _____

Approved %:_____ Fam/ Unit: _____ $_____ Denied: _____

Reason:_____

Patient Information:

Patient Name:_____ Phone Number:_____

Patient Date of Birth: _____ Social Security Number: _____

Patient Address: _____

Patient an Illinois resident at time of service? (circle one) **YES** **NO**

Patient involved in an alleged accident? (circle one) **YES** **NO**

Patient victim of an alleged crime? (circle one) **YES** **NO**

Patient Social Security Number:_____

If applicable: Guarantor Information (if patient is a minor or spouse/ partner is responsible for patient):

Guarantor Name:_____

Guarantor Address:_____

Guarantor telephone or cell phone number:_____

Family Household Information:

Number of persons in the patient's family/household:_____

Number of persons who are dependents of the patient:_____

List the ages of the dependents in the household:

Dependents	Age
Dependent 1	
Dependent 2	
Dependent 3	
Dependent 4	
Dependent 5	
Dependent 6	

Patient's Family Income and Employment Information:

Patient—are you employed? (circle one) **YES** **NO**

If yes, please complete the following:
Name of employer:_____

Address of employer:_____

Telephone number of employer: _____

Spouse of patient-- are you employed? (circle one) **YES** **NO**

If yes, please complete the following:
Name of employer:_____

Address of employer:_____

Telephone number of employer: _____

If the patient is a minor, is the parent or guardian of the minor employed? (circle one) **YES** **NO**

If yes, please complete the following:
Name of employer:_____

Address of employer:_____

Telephone number of employer: _____

If the patient is a minor, it the other parent or guardian of the minor employed? (circle one) **YES** **NO**

If yes, please complete the following:
Name of employer:_____

Address of employer:_____

Telephone number of employer: _____

Marital status of the patient (please circle one): **Single** **Married** **Widowed** **Separated*** **Divorced***

***If the patient is separated or divorced, is the financial responsibility for medical care set forth in the dissolution agreement or court order?** (circle one) **YES** **NO**

Gross monthly family income:

$	Total household employment income (including self-employed)
$	Unemployment compensation
$	Social Security
$	Social Security Disability
$	Veterans' pension
$	Veterans' disability
$	Workers' Compensation
$	Temporary Assistance or Needy Family
$	Private disability
$	Retirement Income
$	Child Support, alimony or other spousal support
$	Other income
$	**Total gross monthly family income**

Please provide documentation of the following:

Paycheck stubs (last 2)
Benefit Statements
Award Letters
Court orders
Federal tax returns
Other documentation in support of income

Are you enrolled in any of the following? (circle all that apply)

Women, Infants, and Children Nutrition Program (WIC)
Supplemental Nutrition Assistance Program (SNAP)
Illinois free Lunch and Breakfast Program
Low Income Home Energy Assistance Program (LIHEAP)
IHDA's Rental Housing Support Program
Temporary Assistance for Needy Families (TANF)
Receipt of grant assistance for medical services
Any community- based program that provides assess to- medical care based on low-income financial status

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 int his 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.

Patient or applicant's signature:_____ Date:_____

If a patient meets the presumptive eligibility criteria of Katherine Shaw Betha Hospital or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures.

****Please note that additional charges may apply if your physician changes the ordered services. This excludes durable medical equipment, physician, surgeon, anesthesiologist, pathologist, and radiology services. These fees are billed separately by their respective billing agents and are not covered by any discount offer or estimate. Examples of these agencies includes: Rockford Anesthesiologists Associated, Rockford Radiology Associates, Miller Eye Center and others.***

LETTER OF SUPPORT

Date:_____

Name(s):_____
(Person(s) that provides room & board)

Address:_____

Phone # (s):_____

I/We provide room & board to:_____
(patient's name)

Since (date):_____ to present.

Relationship to Patient:_____

Signature:_____

Subscribed to and sworn before me   ***This _____ day of _____, 20_____***
Notary Public