Date:____________________________________

Mr.(s):___________________________________

The following documentation is required to apply for Financial Assistance/Charity Care with Katherine Shaw Bethea Hospital. Please return all documents which apply to you to the address below within the next 30 days so we may determine your eligibility. Patients have 240 days from after the date that the first post-service billing statement is provided to apply.

- ***The KSB Financial Assistance/Charity Care policy is focused on serving underinsured and uninsured patients.***
- **Identification with current proof of residency within the state of Illinois**
  (Driver's license, State ID, Temporary visitor's driver's license Lease agreement, mortgage statement or utility bill)
- **The balance is over $150.00 and is not a collection account**
- **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/Charity Care Application 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 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 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 at what percent and what will be patient responsibility.

Not Covered by Financial Assistance/Charity Care

The following list of services and items that are not covered under KSB Hospital's Financial Assistance/Charity Care Program. Please Note: this list is not all inclusive and may be subject to changes. Each case will be reviewed individually.

- Balances <$150.00
- 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 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 include: Rockford Anesthesiologists Associated, Rockford Radiology Associates, and others.**

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

FINANCIAL ASSISTANCE/CHARITY CARE PROGRAM

2024 Family Income Guidelines

Uncompensated Care Eligibility Determination

Effective January 12, 2024

Family Size	2024 Poverty Level	200%	250%	300%
For Individuals	$15,060	$30,120	$37,650	$45,180
For Individuals of 2	$20,440	$40,880	$51,100	$61,320
For Individuals of 3	$25,820	$51,640	$64,550	$77,460
For Individuals of 4	$31,200	$62,400	$78,000	$93,600
For Individuals of 5	$36,580	$73,160	$91,450	$109,740
For Individuals of 6	$41,960	$83,920	$104,900	$125,880
For Individuals of 7	$47,340	$94,680	$118,350	$142,020
For Individuals of 8	$52,720	$105,440	$131,800	$158,160
For Individuals of 9+	Add $5,380 for each extra person	$10,760	$13,450	$16,140

***For families/households with more than 8 persons, add $5,380 for each additional person.**

FPL Range	Additional Discount
< = 200%	**100%**
>200% and < = 250%	**60%**
>250% and < = 300%	**40%**
301% and higher	**0%**

Katherine Shaw Bethea Hospital
Financial Assistance/Charity Care Application

Important: YOU MAY BE ABLE TO RECEIVE DISCOUNTED CARE. Completing this application will help KSB Hospital determine if you can receive free or discounted services or other public programs which 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 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.

Please complete this form and submit it to the hospital in person, by mail, email, or fax to apply. Patients have 240 days after the date that the first post-service billing statement is provided to apply. ***You will receive a final determination letter via mail within 30 days upon receipt of all required documents.***

Patient acknowledges 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/charity care.

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**

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	

Optional Questions:
<u>responses or nonresponses will not have an impact on the outcome of the application</u>

Applicant's Race:______________________________

Applicant's Ethnicity:______________________________

Applicant's Sex:______________________________

Applicant's Preferred Language:______________________________

<u>Patient's Family Income and Employment Information:</u>

<u>Patient—are you employed?</u> (circle one) **YES** **NO**

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

Address of employer:______________________________

Telephone number of employer: ______________________________

<u>Spouse of patient-- are you employed?</u> (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, is 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**

Do you file income taxes? (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

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

Court orders
Federal tax returns
Other documentation in support of income

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 access 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 if I knowingly provide untrue information in this application, I will be ineligible for financial assistance/charity care, and any 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 include: Rockford Anesthesiologists Associated, Rockford Radiology Associates, and others.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance/chart care process may be reported to the Health Care Bureau of the Illinois Attorney General
1-877-305-5145 or illinoisattorneygeneral.gov/consumers/healthcare

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