



The Illinois Uninsured Discount

What you should know.....

The Illinois Uninsured Discount Patient Act became law on April 1, 2009. The act requires all hospitals to provide discounts to uninsured patients meeting certain eligibility requirements.

Those Eligibility requirements include:

- ✓ You must be an Illinois resident
- ✓ You must be a hospital patient without any insurance or coverage
- ✓ You must meet certain Income eligibility requirements based on your family size and income
- ✓ Your hospital charges must be greater than \$300
- ✓ The services you receive must be medically necessary. The discount does not apply to elective cosmetic surgery or non-medical services such as social or vocational services
- ✓ You must apply for the discount within 60 days after the date of service or discharge date.
- ✓ You may be required to apply for Medicare, Medicaid, AllKids, SCHIP, or other public program if there is a reason to believe that you would qualify

You will be asked to fill out an application and provide certain types of information to help verify your gross income and family size (see the reverse side of this form for help in gathering gross income information). Acceptable forms of information to help establish gross income include any one of the following:

- A copy of the most recent tax return
- A copy of the most recent W-2 forms and 1099 forms
- Copies of the 2 most recent pay stubs
- Written income verification from an employer if paid in cash
- One other reasonable form of third party income verification deemed acceptable to the hospital

The Illinois Uninsured Discount does not apply to things such as doctor's office visits or home care visits. However, you may still apply for OSF Charity to help pay for these types of services.

To learn more about the Illinois Uninsured Discount, contact the Patient Accounts Office at OSF Holy Family Medical Center, 309-734-1431, ext. 346, (if no answer, dial 309-734-1401). In addition, OSF HealthCare offers charity care discounts for all patients who qualify. An application for the Illinois Uninsured Discount and/or for the Charity Care discount may be obtained by calling Patient Accounts at OSF Holy Family between 9:30 a.m. and 6 p.m., Monday through Friday. Applications are also available online at www.osfhealthcare.org.

Please review your most recent tax Federal 1040 Tax Form for the information listed below. The corresponding line from your tax return is listed to help you easily find this information. List both the previous tax year (under the "Last Calendar Year" section) and any updates you have for "This Calendar Year".

(If married and filing separately, please include Income of both Husband and Wife)

	IRS Form 1040 Line	Last Calendar Year	This Calendar Year
Wages, Salaries, Tips, Etc.	7		
Interest - Taxable	8a		
Interest - Tax-Exempt	8b		
Dividends	9a		
Tax Refunds, Offsets, Credits	10		
Alimony Received	11		
Business Income or (Loss)	12		
Capital Gain or (Loss)	13		
Other gains or (Losses)	14		
IRA Distributions	15a		
Pensions and Annuities	16a		
Rental real estate, Royalties, Partnerships, S Corporations, Trusts	17		
Farm income or (Loss)	18		
Unemployment Compensation	19		
Social Security Benefits	20a		
Other Types Of Income		Additional Income	
Child Support Received			
Worker's Compensation			
Public Assistance or Welfare			
Veteran's payments			
Survivor benefits (other than pensions and annuities)			
Disability benefits			
Educational assistance, grants and scholarships			
Litigation settlements or judgments			
Other income			
Deductions			
Child Support Paid			

[DEFINITIONS]

- **Investment Income:** Income produced by money or property invested in business ventures, securities, or otherwise, for the purpose of producing a profit.
- **Dependent(s):** The number of persons the Applicant may claim as a personal exemption on the Applicant's Federal Income Tax Return.

[For OSF HealthCare Use Only]

Date Received: _____

Account Nos: _____

Total Balance Due: _____

Total Adjusted Gross Income: _____

Total Dependents: _____

Liquid Assets: _____

Approved Charity \$ _____

Approved Charity % _____

Application Denied for the following reasons:

Signature: _____

Title: _____

Date: _____

OSF St. Francis Hospital
3401 Ludington St., Escanaba, MI 49829-1377
(906) 786-5707 ext. 5550

OSF Saint Anthony Medical Center
5666 E. State Street, Rockford, IL 61108-2472
(815) 395-5070

OSF Saint James – John W. Albrecht Medical Center
2500 W. Reynolds Street, Pontiac, IL 61764
(815) 842-4902

OSF St. Joseph Medical Center
2200 E. Washington Street, Bloomington, IL 61701-7143
(309) 662-3311 ext. 1241

OSF Saint Francis Medical Center
530 N.E. Glen Oak Avenue, Peoria, 61637-0002
(309) 686-6700 or 800-421-5700

OSF St. Mary Medical Center
3333 N. Seminary, Galesburg, IL 61401-1299
(309) 344-3161 ext. 1121

OSF Saint Clare Home
5533 N. Galena Road, Peoria Heights, IL 61614
(309) 682-5428

OSF Medical Group Common Business Office
P.O. Box 1806, Peoria, IL 61656-1806
(800) 589-6070

OSF Home Care
2265 W. Altorfer Road, Peoria, IL 61615-1807
(309) 683-7725



www.osfhealthcare.org



[Dear Patient]

The philosophy of OSF HealthCare is that all people have a right to receive needed health care. Our doors are open to persons of every faith and ethnic background regardless of their ability to pay.

We provide help to patients in obtaining payment from third parties such as Medicaid and Medicare. If you are eligible for Medicaid, and you are not currently signed up, we can help you apply.

We also offer charity assistance for medically necessary healthcare services to persons who meet our financial eligibility terms provided they submit the needed documents. OSF Charity Assistance may be applied for when there is a potential balance due on an account after we have received payment from third party payers (like Medicaid, Medicare or an insurance company) and you feel you cannot pay the full balance.

The attached form must be completed and signed by you. We use income guidelines established by the U. S. Dept. of Health and Human Services to determine if you are eligible for charity care. We do verify assets regarding your eligibility. So, please provide all the information promptly so we may try to help you as quickly as possible.

If you have any questions about OSF Charity Assistance or any other offers of assistance, please call our Patient Accounts office of the facility billing you between 8 a.m. and 4 p.m., Monday through Friday.

OSF HealthCare offers high quality healthcare and we were pleased to care for your family. We look forward to working with you further to make sure the financial aspects of your care are handled in the same high quality way.

Sincerely,
The Sisters of the Third Order of St. Francis

[OSF Charity Assistance Application] (PLEASE PRINT)

Did you receive OSF charity care within the last year? Yes No If yes, from which facility? _____

Name	Patient	Guarantor	Spouse
Address - Street, City, State & Zip Code			
Home Phone			
SS#			
Date of Birth			
Employer			
Employer's Phone			
Hire Date			
Salary/Hourly Wage			
# Hours Worked/Week			
Gross Annual Wages			
Adjusted Gross Income <small>(from Federal Income Tax Form)</small>			

Total Number of Dependents** _____

1. _____ Date of Birth _____ Full Name _____ Date of Birth _____
 2. _____ Date of Birth _____ Full Name _____ Date of Birth _____

Marital Status: Single Married Widowed Separated Divorced

[Other Monthly Income]

SS/SSI: \$ _____ Public/Township Assistance: \$ _____ Alimony/Foster Care/Child Support: \$ _____
 Rental Income: \$ _____ Pension: \$ _____ Trust Fund: \$ _____ TOTAL Other Monthly Income: \$ _____

[Assets]

Checking/Accounts: _____ Account Balance & Date: \$ _____
 Savings/Money Market/CD Accounts: _____ (List Name and Address of Institution) Account Balance & Date: \$ _____
 Stocks/Bonds/Mutual Funds: _____ (List Name and Address of Institution) Current Market Value & Date: \$ _____

[DOCUMENTATION REQUIRED]

OSF Charity Assistance is subject to, and will be reversed if the Applicant fails to first apply for, all other available medical benefits including Public Aid Benefits, if applicable.

The following documentation must be attached to the fully completed and signed OSF Charity Assistance Application and submitted to the OSF HealthCare hospital, OSF Medical Group or OSF Home Care provider, or OSF nursing home facility billing the account(s):

- Copies of your four most recent pay check stubs.
- Proof of all income benefits that you are receiving including pension, social security, unemployment, disability, and child support, alimony and foster care payments.

— A copy of your most recently filed Federal Income Tax Return including all Schedules, W-2 Statements, and 1099 Forms. If you did not file a Return for the

most recent filing period, your Application must include an explanation of the reasons why no Return was filed.

— Proof of denial of Public Aid Benefits (if applicable).

— If you are unemployed with no source of income, a statement explaining how you pay for your basic living expenses.

— For OSF Medical Group providers, both sides of all medical benefit cards and identification of all covered persons.

— Please submit this application within 30 days of receiving it.

If you have any questions, please contact the Patient Accounts Department that is billing the amounts due for healthcare services.

I certify that everything stated in this Application and on any attachment is correct. You may keep this Application whether or not it is approved. By signing below, I authorize you to verify all information submitted. I agree to immediately supplement my Application with any changed financial circumstances. Charity assistance may be extended to subsequent treatment subject to full disclosure of any additional financial information requested. I understand that I cannot apply for, and/or charity may be reversed, if I have a pending liability claim, worker's compensation claim, insurance claim, or my Application contains false or incomplete financial information.

Signature: _____

Date: _____

* Definitions on reverse side