Plain Language Summary

Sarah Bush Lincoln (SBL) 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 Assistance Programs

A fully completed SBL 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 (FPG) in excess of 190% of Federal Poverty Guidelines 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 FPG to determine financial responsibility under a sliding fee scale. Family income below 190% of the FPG qualifies for a 100% charity discount. All insurance benefits must be exhausted to qualify.

3. Illinois 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% the 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 an Application Form

The SBL Financial Assistance Policy and the application form may be obtained free of charge.

- See reverse side of this application
- Available at:
  - the SBL hospital lobby reception desk
  - the SBL Patient Financial Services office
  - the main reception desk of any SBL hospital-owned clinic
- To have the application form mailed to you, call or write:
  - **800-381-0040** (SBL Patient Financial Services)
  - Sarah Bush Lincoln
PO Box 372
Mattoon, Illinois 61938
- Download the form from the SBL website: **www.sarahbush.org**

Assistance

Patient Financial Services representatives are available to assist in completion of the application:

- 8:30 am to 4:30 pm
Monday through Friday
- Financial Counselor Office
1000 Health Center Drive, Mattoon
Located in the Hospital, Entrance A

This Summary, the Financial Assistance Policy, and the application form are available in Spanish at the locations listed above.

Revised October 2022

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported 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.

Have billing questions or need further assistance?

SBL Patient Financial Services

phone • **800-381-0040**
fax • **217-258-2216**
email • **sblbillingquestions@sblhs.org**

8 am – 4:30 pm
Monday to Friday

www.sarahbush.org

Sarah Bush Lincoln

Financial Assistance Program

Enhanced to better serve people with greater financial needs.

SBL Financial Assistance Program

You may be able to receive free or discounted healthcare.

Completing this application will help Sarah Bush Lincoln determine if you can receive free or discounted healthcare, or if other public programs can help pay for your healthcare.

If you are uninsured, a Social Security number is not required to qualify for free or discounted healthcare. However, a Social Security number is required for some public programs, including Medicaid. Providing a Social Security number is not required, but will help determine whether you qualify for any public programs.

By completing this application, the patient acknowledges that he or she has made a good-faith effort to provide all information requested to assist Sarah Bush Lincoln in determining whether the patient is eligible for financial assistance.

SBL works with community members to help simplify the business aspect of its relationship. For example, it will help patients obtain payment from third parties, such as Medicaid and Medicare, by answering the patients questions and assisting with applications. It offers financial assistance to patients who meet the financial terms once they've submitted the necessary paperwork. It also encourages patients to apply for financial assistance when they cannot cover account balances after payments are received from third-party payers (like Medicaid, Medicare and other insurance companies).

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

APPLICATION

SBL Financial Assistance

If you have questions, please call **800-381-0040**.

Name ______________________________

Date of Birth ______________________________

Address ______________________________

____

Social Security # ______________________________

Not required if you are uninsured.
Not required for National Health Service Corps sites.

Phone # ______________________________

Optional

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

Race ______________________________

Ethnicity ______________________________

Sex ______________________________

Preferred Language ______________________________

Family/Household Members

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Employment Information

Patient's Employer Name

____

Patient's Employer Address

____

Spouse/Partner/Guarantor Employer Name

____

Spouse/Partner/Guarantor Employer Address

____

Insurance Information

Health Insurance Name

____

- ❑ Medicaid
- ❑ Medicare
- ❑ Medicare Supplement Name

____

DOCUMENTATION

SBL medical bills will continue to be sent to you until a completed application is returned. Before the application may be processed, copies of supporting documentation must be submitted with application.

To apply for the Illinois 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
- 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. The last two years tax forms are needed 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 and child support received
- ❑ Letter from public programs (Social Security, Veterans, Public Aid) listing amount received
- ❑ Verification of all other income
- ❑ Public Aid approval or denial letter if applicable - pregnant, dependent children, disabled, blind, over age 65

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

- Verification of household income
- Checking and savings account informations
- Investments – CDs, stocks, bonds, retirement accounts

Not required for National Health Service Corps sites.

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 Signature

____
Signature Date

Please complete this form and all additional documentation.

Submit in person –
Financial Counselor Office
1000 Health Center Drive, Mattoon
Located in the Hospital, Entrance A

Mail to –
Sarah Bush Lincoln Patient Financial Services
1000 Health Center Drive
PO Box 372
Mattoon, IL 61938