Advocate Health Care

SUMMARY OF ADVOCATE HEALTH CARE's CHARITY CARE POLICY

It is the policy of Advocate Health Care to provide financial assistance to patients in need. Advocate hospitals will extend medically necessary services free-of-charge, or at a reduced amount, to an individual who is eligible under the following criteria.

Charity Care decisions are based on the family's "gross income," which means gross earnings reportable to the federal government. An uninsured patient whose family's gross income does not exceed six times the Federal Poverty Level ("FPL") may qualify for Charity Care. The FPL varies with the size of the family and is updated annually. You may also be granted Charity Care if you can show extenuating financial circumstances (such as large outstanding medical bills).

The following table will be used to make the Charity Care determinations:

Multiple of FPL	0 - 2	2 - 3	3 - 4	4 - 6 (Uninsured Illinois residents with a balance >$300)
Expected Payment	$0	Hospital's Cost of Services Provided	Hospital's Cost of Services Provided	135% of the Hospital's Cost of Services
Maximum Expected Payment	$0	5% of Family Income	10% of Family Income	25% of Family Income

To qualify for Charity Care, you must complete the attached application form and mail or deliver it to the Advocate Hospital where you were treated. All communications with the patient or family members will be handled in strict confidence and in a compassionate manner. The application requires you to certify your family's current monthly income, and provide proof in the form of W-2 forms, tax return or pay stubs if available. If you cannot provide such documents, the determination will be based on your certification of your family's income. It is your responsibility to cooperate with Advocate by filling out the application and providing the requested information if possible, and also by helping Advocate seek payment from health insurers or the government if such payment might be available. While your application for Charity Care is pending, Advocate will not try to collect the bills for which you are seeking assistance.

If you apply for Charity Care, the Advocate Hospital will notify you whether your application has been approved or denied. If you disagree with Advocate's decision, you may appeal the decision within 45 days.

You may also contact the hospital's financial counselor for assistance with your application, questions and appeal status at **847-723-5061.**

Return your completed application and documents to the hospital at the following address:

Advocate Lutheran General Hospital
ATTN: Business Office/Financial Counselor
1775 Dempster Street
Park Ridge, IL 60068

If you have previously submitted a charity care application in the past 45 days and would like to know the status please call the Financial Counselor at the phone number on your bill. You do not need to submit another charity care application at this time.

Advocate Health Care

Charity Care Application **Patient Account Number**(s): _____

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.

PATIENT INFORMATION

Email Address						
Last Name	First	M.I.	Date of Birth	Social Security Number - -		Family Size
Street	Apt. #	City	State	Zip Code	Home Phone	
Employer		Address			Cell Phone	
City	State	Zip Code	Monthly Income		Work Phone	

SPOUSE / (PARENT INFORMATION IF MINOR)

				Relationship to Patient	Date of Birth
Email Address					
Last Name	First	M.I.	Social Security Number - -		Home Phone
Employer		Address			Cell Phone
City	State	Zip Code	Monthly Income		Work Phone

INCOME INFORMATION

Please provide one or more of the following for each employed family member and sign the statement below.

1) a copy of most recent tax return
2) a copy of most recent W-2 and 1099 Forms
3) a copy of most recent pay stub

If you cannot provide any documentation relating to your income, fill out the statement below:

I, _____(name), certify that I have no documents that prove my family's monthly income of $_____. I understand that if the above information is untrue, any charity granted to me may be forfeited**,** future requests may be denied and I will be responsible for payment of the hospital bill.

OTHER INFORMATION

If you have additional documents that may help Advocate make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: phone bills, electricity bills, medical bills, bank or checking statements, etc….)

APPLICANT CERTIFICATION: I certify that the above information is true and complete to the best of my/our knowledge. I understand that as part of the financial screening process, my/our address, employment and credit history may be verified. I authorize Advocate to obtain copies of my tax returns from the Internal Revenue Service and the Illinois Department of Revenue.

Applicant Signature: _____ Date: _____

If you have submitted a charity care application in the past 45 days and would like to know the status of your application please call the Financial Counselor at* 847-723-5061*.

Return your completed application and documents to the hospital at the following address:

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Park Ridge, IL 60068