ELIGIBILITY CRITERIA
FINANCIAL ASSISTANCE PROGRAM

The table below is based upon 2017 Federal Poverty Guidelines (FPG).

Family Size	2017Federal Poverty Guidelines	200%	600%
1	$12,060	$24,120	$72,360
2	$16,240	$32,480	$96,440
3	$20,420	$40,840	$122,520
4	$24,600	$49,200	$147,600
5	$28,780	$57,560	$172,680
6	$32,960	$65,920	$197,760
7	$37,140	$74,280	$222,840
8	$41,320	$82,640	$247,920
9	$45,500	$91,000	$273,000
10	$49,680	$99,360	$298.080

CALCULATION PROCESS

The matrix below is to be utilized for determining the level of assistance for patients who are uninsured.

1. Patients who are uninsured **and at or below the** 200% FPG guideline will receive a full write-off of charges.
2. For uninsured patients who **exceed the 200% FPG guideline**, **but have income less than 600% FPG** guideline, a sliding scale will be used to determine the percent reduction of charges that will apply. The matrix for the discount provided is noted below.

Eligibility Criteria	
Percentage of Poverty Guidelines	**Discount Percentage**
Up to 200%	100%
201 - 300%	90%
301 - 400%	80%
401 – 600%	75 %

Presence Health℠

MEDICAL GROUP FINANCIAL ASSISTANCE APPLICATION COVER LETTER

Presence Health –Presence Medical Group offers financial assistance programs to meet the needs of our patients. The programs listed below apply only to Presence Medical Group charges.

In addition to the Presence Health –Presence Medical Group Financial Assistance Programs, you may also be eligible for public programs such as Medicaid, Medicare or All Kids. Applying for such programs may be required prior to applying for a Medical Group Financial Assistance Program.

Financial Assistance Programs include:

Program	Available to	Description	How to Apply
Uninsured Financial Assistance	Uninsured Patients	Offers free care or discounted care based on family size and income according to the Federal Poverty Guidelines	Complete the Financial Assistance Program Application
Payment Plan Program	Uninsured and Insured Patients	Assists patients with their financial obligations by establishing payment arrangements	Contact the Medical Group Central Billing Office at (630) 914-2494

To help us determine if you are qualified to receive financial assistance, please complete, sign and return the enclosed application along with copies of the following applicable documents:

- ☐ Federal Income Tax Return (or) 2 most recent paycheck stubs or other proof of income
- ☐ Driver's License or State-issued ID

If applicable, please submit the following:

- ☐ Food Stamp Award Letter
- ☐ Room and Board Statement (available at (www.presencehealth.org/financialassistance) or a Written Letter of Support if no income
- ☐ Social Security Award Letter
- ☐ Unemployment Compensation Benefit Award Letter

Return completed form and supporting documents to:

Presence Health - Presence Medical Group
Financial Assistance Committee
1000 Remington Blvd., Suite 100
Bolingbrook, IL 60440

We will respond to you within 45 days of reviewing the completed application and supporting documents. If you have any questions or need additional assistance, please contact us at (630) 914-2494 orwww.presencehealth.org/financialassistance to obtain additional information on our Financial Assistance Programs

Presence Health℠

Room and Board Statement

_____
Patient Name: (Print)

The person named above has advised us that you either contribute substantially to their support or you are their sole means of support.

The type of support I / we provide is: (please complete all that apply)

_____ Room and Board, since (date) _____

_____ Allowance of $ _____

_____ Every week
_____ Every two (2) weeks
_____ Every month

_____ Other (please explain)

_____

_____

I / We, (print) _____ have been the sole/substantial support for the person named above and, to the best of my / our knowledge, declare that this person has no other primary means of support. I/We will continue to provide room and board, but will not be responsible for medical expenses incurred.

_____	_____
Signature 1	**Signature 2**
_____	_____
Relationship to Patient	**Relationship to Patient**
_____	_____
Address, Street	**City, State Zip**
_____	_____
Telephone	**Date**

NOTE: This application is for Presence Health -Presence Medical Group Charges Only.

Presence Health – Presence Medical Group

Date of Application:_____

1. PATIENT INFORMATION *: **-PLEASE PRINT ALL INFORMATION-**

Last Name	First Name	M.I.

*** If the patient is a minor or full-time student, please list parent(s)/guardian(s) as applicant and co-applicant**

2. APPLICANT (PATIENT/PARENT) INFORMATION: **Relationship to Patient:**(circle): Self Spouse Parent Other
Marital Status (circle): Single Married Divorced Separated

Last Name	First Name	M.I.	Social Security Number	DOB

Address	Phone

Current Employer	Street Address	Phone	Years Employed

3. CO-APPLICANT (SPOUSE/PARENT) INFORMATION: **Relationship to Patient:**(circle): Self Spouse Parent Other

Last Name	First Name	M.I.	Social Security Number	DOB

Address	Phone

Current Employer	Street Address	Phone	Years Employed

Total Number of Dependents: (other than self and co-applicant)	**Dependent Name**	**Date of Birth**	**Relationship**

4. INCOME INFORMATION:
List all contributing gross household income. Include gross wages, salaries, dividends, interest, social security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, trusts, and veteran stipends.

Monthly Household Income Sources Check those that apply and give amounts	
☐ Employment Income	$
☐ Social Security	$
☐ Disability	$
☐ Unemployment	$
☐ Spousal/Child Support	$
☐ Rental Property	$
☐ Investment Income	$
☐ Other:	$
☐ Other:	$
Total <u>Monthly</u> Income	

If you do not have monthly income, you will need to provide information as to who is providing you with room and board. Please complete the Room and Board Statement as documentation that you do not have monthly income.

5. ADDITIONAL INFORMATION/COMMENTS:

Applicant Signature	Date	Co-applicant Signature	Date

6. SIGNATURE: Completion of this form is not a guarantee of eligibility for Financial Assistance, or any other program. By signing I certify that all information is valid and complete. I will immediately notify Presence Health – Presence Medical Group if my financial circumstances change.

Return completed form and supporting documents to:
Presence - Resurrection Medical Group
Financial Assistance Committee
1000 Remington Blvd., Suite 100
Bolingbrook, IL 60440

If you have any questions or need additional assistance, please contact us at 630-914-2494 or visit www.presencehealth.org/FinancialAssistance for additional information.

*

FINANCIAL ASSISTANCE EXPENSE FORM

Presence Health™

1. PATIENT NAME	PLEASE PRINT ALL INFORMATION	
LAST Name	First Name	Middle Name
2. INSTRUCTIONS:		
Please complete the following information in its entirety and return to the address below.		
3. ESTIMATED MONTHLY LIVING EXPENSES:		
Monthly Expenses	Monthly Payment	List Other Monthly Payments
House /Mortgage/Rent Payment	$	
Property Taxes (if not included in Mortgage)	$	
Home Owners Insurance (if not included in Mortgage)	$	
Food	$	
Telephone (Home/Cell)	$	
Child Support	$	
Spousal Support /Alimony	$	
Child Care	$	
Credit Cards Total balance owed:$	$	
Health Insurance Premiums	$	
Monthly Medical Expenses	$	
Total Outstanding $	$	
Medical Balance	$	
Automobile Insurance	$	
Automobile Gasoline	$	
Liens/Wages Garnishes	$	
Prescriptions	$	
Utilities: Electric	$	
Utilities: Gas	$	
Utilities: Water	$	
TOTAL MONTHLY PAYMENTS		
4. ADDITIONAL INFORMATION /CIRCUMSTANCES FOR CONSIDERATION		
5.SIGNATURE		
By signing below I certify that all information is valid and complete. I will immediately notify Presence Medical Group. If my circumstances change.		
Applicant Signature	Date	Co-Applicant Signature

Return completed form to:

Questions (630) 914-2494

www.presencehealth.org/financialassistance

Presence Medical Group
Financial Assistance Committee
1000 Remington Blvd. Suite 100
Bolingbrook, Il 60440

5/2016