Mercyhealth
A passion for making lives better.™

Rockford Memorial Hospital
Financial Assistance Eligibility Guidelines and Application

It is the policy of Mercyhealth to provide financial assistance to patients in need. Rockford Memorial Hospital (RMH) will extend medically necessary services free-of-charge, or at a reduced amount, to an individual who is eligible under the following criteria. RMH also follows the Illinois Hospital Uninsured Patient Discount Act.

IMPORTANT: You may be able to receive free or discounted care: Completing this application will help us determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please complete this form and submit it to the hospital in person, by mail (2400 North Rockton Avenue, Rockford, IL 61103), by electronic mail (rmhpfs@mhemail.org), or by fax (815-968-0170) to apply for free or discounted care within sixty (60) days following the date of discharge or receipt of outpatient care.

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.

If you apply for Charity Care, RMH will notify you whether your application has been approved or denied. If you disagree with our decision, you may appeal the decision within 30 days in writing with additional documentation.

If you are **uninsured**, a social security number is not required to qualify for free or 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.

If you are **uninsured,** presumptive eligibility criteria are used to determine if a patient is eligible for hospital financial assistance without further scrutiny by the hospital. Please check any of the items listed below that apply to you:

_____ Homeless
_____ Medicaid eligible
_____ Patient is deceased with no estate
_____ Supplemental Nutrition Assistance Program (SNAP or LINK)
_____ Temporary Assistance for Needy families (TANF)
_____ Patient has mental incapacitation with no one to act on patients behalf
_____ Women, Infants and Children Nutrition Program (WIC)
_____ Illinois Free Lunch and Breakfast Program
_____ Low Income Home Energy Assistance Program (LIHEP)
_____ IDHA Rental Housing Support Program
_____ Receipt of grant assistance for medical services

Patient acknowledges that 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.

To qualify for Charity Care, you must complete the attached application form on the opposite side of this page and mail or deliver it to RMH. All communication 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. While your completed application for Charity Care is pending, RMH will not try to collect the bills for which you are seeking assistance.

Please call our RMH Business Office at **815-971-6313** or **800-987-4170** should you have any questions.

OVER

Date: _____

Patient Account No. _____

RMH Representative: _____

Rockford Memorial Hospital
Financial Assistance Application

Guarantor Name: _____ Birth Date: _____

Home Address: _____ Phone Number: _____

_____ Cell Number: _____

_____ Email Address: _____

Employer: _____ Years Employed: _____

Social Security No. _____ (not required if you are uninsured)

Spouse Name: _____ Birth Date: _____

Spouse Employer: _____ Years Employed: _____

Identify and list the number of dependents as shown on tax return: _____

NAME	RELATIONSHIP to APPLICANT	AGE of DEPENDENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Gross Monthly Family Income

Wages	$_____	Pension	$_____
Self-employment	$_____	Retirement Income	$_____
Unemployment	$_____	Child Support, Alimony	$_____
Social Security	$_____	Workers' Compensation	$_____
Social Security Disability	$_____	Other Income	$_____

If you have no income, please explain your living arrangements: _____

_____

By signing below, I certify that the information is 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. RMH may obtain a personal credit bureau report to verify outstanding obligations. 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.

_____ _____ _____ _____

Patient/Guarantor Signature Date Spouse's Signature Date

Revised 10/04; 03/05; 08/07; 10/07; 01/08; 02/11; 01/14; 09/17