Mercyhealth™
A passion for making lives better.

MERCY HARVARD HOSPITAL

ILLINOIS HOSPITAL UNINSURED PATIENT DISCOUNT APPLICATION
Instructions

A patient who meets certain income requirements may qualify for an uninsured discount. The patient must apply for the discount within 60 days of the date of discharge or date of service.

Who May Apply?
Any uninsured Illinois resident with Illinois hospital charges. An uninsured patient is not covered under any third party coverage. This includes high deductible plans, workers' compensation, accident liability insurance, or other third party liability. The discount only applies to an uninsured patient who is not a beneficiary under any type of plan. A patient that is insured, but not covered for a particular service, is still defined as being insured.

What Discount am I Eligible for?
The discount is applied for hospital inpatient or outpatient charges only when the charges are over $300 in one inpatient admission or outpatient encounter. The discount applies only to services that are considered to be medically necessary. The discount does not apply to cosmetic surgeries or social and/or vocational services. The discount does not apply to hospital-based physician services. A more detailed description of the discount can be found in Mercy Health Corporation's Financial Assistance Policy.

Hospitals cannot collect more than 25% of an uninsured patient's family gross income in any 12-month period. The 12-month period begins on the date of service for which the hospital first determined the patient is eligible for the discount. Thereafter, for any subsequent hospital services, the patient **must inform** the hospital that he or she received a discount and continues to be eligible for the discount.

Failure to Provide Documentation or Apply for Public Programs
The Hospital's obligations toward an uninsured patient shall end if the patient fails to provide the requested documentation or apply for coverage under public programs within 30 days of the Hospital's request. Patients who may be eligible for coverage under public programs must first apply to those programs (Medicare, Medicaid, AllKids, SCHIP).

Falsification of Information
The patient forfeits the discount and may be responsible for payment of the Hospital's full charges if the patient has not been fully truthful on the application.

How to Apply:
Complete the application and mail to:

MercyCare Building
580 N. Washington Street-Customer Service Department
PO BOX 5003
Janesville, WI 53547
(608) 741-7630 or toll free (866) 269-7115
e-mail: custserv@mhsjvl.org
Monday through Friday 8am to 4:30pm
Or on our website at www.mercyhealthsystem.org

You may also call 608-741-5658 or ask for a Patient Financial Counselor to assist you in completing the application.

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Applicant: _____ Date of Birth: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Spouse's Name: _____ Date of Birth: _____

	Applicant	**Spouse**
Social Security #:	_____	_____
Employer:	_____	_____
Employer Address:	_____	_____
Employer Phone:	_____	_____
Date of Hire:	_____	_____
Date of Term:	_____	_____
Previous Employer/Dates:	_____	_____

Does your employer offer health insurance as a benefit? ☐ Yes ☐ No

Is your balance related to workers compensation or liability? ☐ Yes ☐ No If yes, date of accident: _____

Dependents Name	Age	Relationship	Dependents Name	Age	Relationship
1.			4.		
2.			5.		
3.			6.		

List Monthly Income and Assets (<u>Indicate Amount and Provide Documentation verifying each</u>). If none, how do you support yourself? _____

□ Savings: _____ □ Checking: _____ □ Investment Property: _____ (other than home & cars)

□ Stocks/Bonds:_____ □ Non-homestead property: _____

□ Wages _____ □ Veterans _____ □ Pension _____

□ Child Support _____ □ Alimony _____ □ Social Security _____

□ IRA Distributions_____ □ 401K Distributions _____ □ 403B Distributions _____

Give amounts and dates you have been receiving the following:

□ Workers Comp $_____ Dates:_____ □ Unemployment $_____ Dates:_____ □ Other $_____ Dates:_____

RELEASE OF FINANCIAL INFORMATION

I, _____, authorize Mercy Health System Corporation ("Mercy") to obtain any financial information held by the Social Security Administration, County Social Services, Credit Bureaus, lending institutions, banks, other financial institutions and insurance companies on myself and my family, for the purpose of determining eligibility for the Hospital Uninsured Patient Discount. This authorization is valid for 1 year from my dated signature. I can revoke it at any time in writing, except, to the extent that Mercy has already acted in reliance on it. I understand that a photocopy of this consent is as valid as the original.

I understand that I give up my right to the discount, and I may be responsible for payment of the Hospital's full charges if I have not been fully truthful in the information provided. I hereby certify that all the information provided in the application is true and correct.

Signature of Applicant: _____Date:_____

If signed by person other than the patient, complete the following and provide the necessary documentation:

Signature of legally authorized person: _____ Date: _____

Patient is: ☐ Minor ☐ Disabled ☐ Legal Guardian

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Or on our website at www.mercyhealthsystem.org

You may also call 608-741-5658 or ask for a Patient Financial Counselor to assist you in completing the application.

Mercy Harvard Hospital's obligation under the Illinois Hospital Uninsured Patient Discount Act shall end if the patient fails to provide the requested documentation or apply for coverage under public programs within 30 days of the Hospitals request.

YOUR APPLICATION CANNOT BE PROCESSED UNTIL YOU HAVE:

☐ 1. Completed and signed the application within 60 days of the date of discharge or date of service.

Included:

☐ 1. Copy of your most recent Federal tax return (ex.1040, 1040A, 1040EZ). If you are self employed, please provide your Federal tax return in it's entirety
☐ 2. Copy of two most recent payroll check stub from all jobs held in current year showing year to date income
☐ 3. Copy of the most recent W-2 form and 1099 forms
☐ 4. Written income verification by an employer if paid in cash
☐ 3. Copy of Verification of unemployment compensation or other fixed income such as veteran's, pension, social security, retirement, injury compensation funds, child support, or disability.
☐ 4. Copy of your last 2 bank statements showing Savings and Checking activity.
☐ 5. If unable to work, must apply for Social Security Disability. Provide documentation that the application is being processed.
☐ 6. Must apply and provide documentation for all medically related resources that apply to your personal situation.

____ **Medical Assistance**
-Must have children under age 19, or be over 65, or disabled, or blind
-Call McHenry Cty. (815) 338-0234

____ **Family Planning**
-For women ages 15 to 45 without health insurance, for birth control assistance
-Call McHenry Cty. (815) 338-0234

____ **Seniorcare**
-For seniors age 65 and older, prescription drug assistance
-Cal McHenry Cty. (815) 338-0234

_____ **Allkids**
http://www.allkids.com/application.html
1-866-ALL-KIDS (1-866-255-5437) TTY: 1-877-204-1012

_____ **State Children's Health Insurance Program**

☐ 7. Denial from any liability insurance if involved in an accident or assault.
☐ 8. If assaulted, must apply with Crime Victim Witness program providing documentation that you have applied for their assistance.
☐ 9. If college student, must provide documentation verifying current student status.

IMPORTANT: If we receive an incomplete application, the accounts may still be at risk for outside collection. Please be sure to send all needed information and verification in order for us to process your application in a timely manner.

Mercy Partner giving application:
_____

Application Due by: