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. We limit nonemergent medically necessary services to uninsured and underinsured individuals residing in the following 10 counties: Clark, Coles, Cumberland, Douglas, Edgar, Effingham, Fayette, Jasper, Moultrie, and Shelby. 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 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 in excess of 130% of Federal Poverty Guidelines (FPG) 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 130% of the FPG qualifies for a 100% charity discount. For each increment of income up to 400% of the FPG, the discount decreases by 10%. All insurance benefits must be exhausted to qualify.

3. IL 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 130% the FPG qualifies for a 100% charity discount. Family Income between 130% 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 Application Form - The SBL Financial Assistance Policy and the Application form may be obtained free of charge.

- See reverse side of this application
- They are available at the Hospital main registration desk or in the Patient Financial Services Office, and at the main registration desk of any Hospital-owned clinic.
- Call SBL Patient Financial Services at 800-381-0040 to have them mailed to you.
- Write to Sarah Bush Lincoln, P.O. Box 372, Mattoon, Illinois 61938 to have them mailed to you.
- Download them from the SBL website: **www.sarahbush.org**

Application Process - Mail completed applications (with all documentation and information specified in the application instructions) to SBL Patient Financial Services, P.O. Box 372, Mattoon, Illinois 61938.

Patient Financial Services representatives are available to assist in completion of the application Monday through Friday, 8:30 am to 4:30 pm at the Financial Counselor Office in the main building of the Hospital. This Summary, the Financial Assistance Policy, and the application form are available in Spanish at the locations listed above.

Revised 7/2020

Have billing questions or in need of further assistance?

Patient Financial Services
Phone: (800) 381-0040
Fax: (217) 258-2216
Monday-Friday 8 am to 4:30 pm
sblbillingquestions@sblhs.org

www.sarahbush.org

Sarah Bush Lincoln

Financial Assistance Program

Enhanced to better serve people with greater financial needs.

Sarah Bush Lincoln
Financial Assistance Program

Important:

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help Sarah Bush Lincoln determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to Sarah Bush Lincoln/Patient Financial Services department.

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.

Please complete this form and submit it to Sarah Bush Lincoln/Patient Financial Services department in person or by mail to apply for free or discounted care within 240 days following the date the first billing statement is mailed to the patient.

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

We will work with community members to help simplify the business aspect of our relationship. For example, we will help patients obtain payment from third parties such as Medicaid and Medicare by answering their questions and assisting them with applications. We offer financial assistance for persons who meet the financial terms once they've submitted the necessary paperwork, and we invite patients to apply for financial assistance when they cannot cover account balances after we've received payments from third-party payers (like Medicaid, Medicare and insurance companies).

If you have any questions about the SBL Financial Assistance Program, please call Patient Financial Services between 8 am and 4:30 pm, Monday through Friday at **(800) 381-0040**.

Financial Assistance forms may be downloaded from **www.sarahbush.org**

Application for SBL Financial Assistance

If you need any help with this form, please call 800-381-0040.

APPLICANT INFORMATION

Name ______________________________

Date of Birth ______________________________

Address ______________________________

____

Social Security # ______________________________
(not required if you are uninsured)

Telephone or cell phone number ____________________

FAMILY/HOUSEHOLD INFORMATION

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

Name ____________________ Birthdate ________

PATIENT'S EMPLOYMENT INFORMATION

Patient's Employer Name ____________________

Patient's Employer Address____________________

Guarantor/Spouse/Partner Employer Name

____

Guarantor/Spouse/Partner Employer Address

____

INSURANCE INFORMATION

Health Insurance Name ____________________

❏ Medicare

❏ Medicare Supplement Name ____________________

❏ Medicaid

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

Have billing questions or in need of further assistance?

Patient Financial Services
Phone: (800) 381-0040
Fax: (217) 258-2216
Monday-Friday 8 am to 4:30 pm
sblbillingquestions@sblhs.org

To apply for the IL 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; or 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 tax forms. Last two years 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 & 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.

Bills will continue to be sent until a completed application is returned. Before the application may be processed, copies of supporting forms must be submitted with application or mailed to:

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

Please see back panel for additional information.

The mission of Sarah Bush Lincoln is to provide exceptional care for all and create healthy communities.