

# Financial Assistance Policy – Plain Language Summary

Rochelle Community Hospital's ("RCH") Financial Assistance Policy ("FAP") exists to provide eligible patients partially or fully discounted emergency or medically necessary healthcare services provided by the hospital. Patients seeking financial assistance must apply for the program, which is summarized herein.

**Eligible Services:** In general, the FAP applies to emergency or medically necessary services provided and billed by RCH.

**Eligible Patients:** In general, patients receiving eligible services at RCH, who submit a complete Financial Assistance Application, and who are determined eligible for financial assistance by RCH.

**How to Apply:** Financial Assistance Applications may be obtained/completed/submitted as follows:

1. Download an application from RCH's website at: <https://www.rochellehospital.com/patients-and-visitors/billing-insurance/financial-assistance/>.
2. Pick up an application at RCH's Emergency Department or other patient access points.
3. Request an application by calling the Patient Financial Services Coordinator at: 815-562-2181 ext. 1600.
4. Completed Applications may be turned in or mailed to:

Rochelle Community Hospital  
Attn: Financial Services Coordinator  
900 North Second Street  
Rochelle, IL 61068

**Determination of Financial Assistance Eligibility:** In general, Eligible Patients may receive financial assistance when their household income is at or below 300% of the Federal Poverty Guidelines. Eligibility for financial assistance means that Eligible Patients will have the cost of their care covered fully or partially, and they will not be billed more than Amounts Generally Billed to insured patients, as defined by Section 1.501(r)-5 of the Department of Treasury regulations. Financial assistance discounts offered by RCH are:

- Free Care: Households with income from 0% to 200% of FPG are eligible for free care for Eligible Services.
- Partially Discounted Care: Households with income between 200% and 300% of FPG are eligible for a 75% discount on Eligible Services.

**Maximum Collectible Amount:** The maximum amount RCH will collect in a 12-month period from a patient determined by RCH to be eligible under this section is 20% of the patient's family income. The 12-month period to which the maximum amount applies shall begin on the first date an uninsured patient receives health care services that are determined to be eligible for the uninsured discount at RCH. To be eligible to have this maximum amount apply to subsequent charges, the uninsured patient shall inform RCH that the patient has previously received health care services from RCH and was approved for the uninsured discount.

Households with over 300% of the Federal Poverty Guidelines in Qualifying Household Assets are not eligible for Financial Assistance at RCH. Qualifying Household Assets includes all checking account balances, savings account balances, health savings account balances, and non-primary residence real estate held by members of the household.

Applicants who provide incomplete Applications will be notified and given an opportunity to provide the missing documentation/information in order for a determination to be made with respect to eligibility for financial assistance.

**Contact Information:** For free copies of the Policy and Application, use the contacts listed above. The full Financial Assistance Policy, this summary, or an application are available in other languages upon request.



Rochelle Community Hospital  
 900 N. 2<sup>nd</sup> Street  
 Rochelle, IL 61068

## APPLICATION FOR FINANCIAL ASSISTANCE

For Rochelle Community Hospital to process your application, all sections must be completed. Along with your application, required documents may include:

- Proof of income for all income sources (previous year's tax return, last 3 pay stubs, social security benefit letters, etc.)
- Most recent bank statements.

### SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information.

Applicant Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

LAST NAME                      FIRST NAME                      MIDDLE NAME

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

(The following questions regarding race, ethnicity, sex, and preferred language are OPTIONAL, and responses or non-responses will not have any impact on the outcome of the application.)

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Sex: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

### SECTION TWO: HOUSEHOLD MEMBERS and INCOME INFORMATION

Please provide the below information for all immediate family members who live in your home. For application purposes, Family is defined as the applicant, the applicant's spouse, and all of the applicant's children under 18 (natural or adoptive) who live in the applicant's home.

Name	Date of Birth	Relationship to Applicant	Total Gross Monthly Income (All Sources)
(Applicant)		self	

If there is no income, please explain how applicant is supporting themselves: \_\_\_\_\_

Was your service related to a Worker's Compensation claim or motor vehicle accident? Yes / No

### SECTION THREE: ASSETS INFORMATION

Please provide any income and assets that members of your household receive.

Asset Type	Current Balance/Value – Applicant	Current Balance/Value – Spouse/Other
Bank Account - Savings		
Bank Account - Checking		
Health Savings Accounts		
Non-Primary Residence Real Estate		

### SECTION FOUR: INSURANCE INFORMATION

Please provide your health insurance/medical coverage information, if applicable.

Insurance Company Name: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

I certify that the above information is true and accurate to the best of my knowledge. I will apply and take any reasonable action needed to get assistance (Medicaid, Medicare, Insurance, etc.) to pay my hospital charges. Financial assistance is a source of last resort. Any other liability or possible payer will be exhausted prior to awarding assistance. I understand that this application is made so that the hospital can see if I am eligible for financial assistance based upon defined criteria.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General – (877) 305-5145.

<https://www.illinoisattorneygeneral.gov/consumers/healthcare.html>