

**HARDIN COUNTY GENERAL HOSPITAL  
PO BOX 2467 6 FERRELL ROAD  
ROSICLARE, IL 62928  
(618) 285-6634**

DEPARTMENT: HOSPITAL WIDE

SUBJECT: FINANCIAL ASSISTANCE/ CHARITY  
CARE AND COMMUNITY  
SERVICE POLICY

REFERENCE: DEPARTMENT OF HEALTH AND HUMAN SERVICES, COMMUNITY  
SERVICE ADMINISTRATION-FEDERAL REGISTER VOLUME 69 NO.30

Hardin County General Hospital will give financial assistance to uninsured individuals who are financially unable to pay for medical care excluding deductible, insurance co-payments, and IDPA spend downs. This community service will only be available to persons residing in the state of Illinois for at least one year, are uninsured, and have attempted to qualify for Illinois Public Assistance.

This assistance will be made without discrimination based upon, race, color, creed, national origin or other grounds unrelated to the individual's need for these services. The hospital will assist the patient in their application for KidCare/ Family Care or for their local State of Illinois Department of Public Aid Human Services. The patient must apply for and be denied assistance and must present a written denial of assistance before their Financial Assistance Application can be processed.

Hospital Uninsured Patient Discount Act: Rural and critical access hospitals are required to provide discounts for uninsured Illinois residents with family income less than 300% of the Federal Poverty Level (FPL). Discount is a minimum of 135% of cost utilizing the ratio of cost to charges from worksheet C Part 1 from the most recent filed Medicare Cost Report. A maximum that can be collected is 25% of income

1 Persons requiring medical care may request a determination of eligibility from the Credit and Collections personnel for financial assistance prior to the service, after the service is provided, or even after collection action has been initiated; however, the hospital reserves the right to require proof of need. This requirement may be proof of income and estimated value of household assets as well as denials from public aid applications. In addition the hospital will require a listing of monthly obligations and expenses. Copies of paycheck stubs, unemployment checks, state and federal IRS tax returns or any other information that is reasonable and necessary to substantiate the applicant's income.

2 Once the information is compiled and reviewed by the Credit and Collections personnel, and a determination is made that the Financial Assistance Application meets the criteria, it will be forwarded to Administration for review. Prompt determination of eligibility will be based on income level set by the current Department of Health and Human Services Poverty Guidelines, using the Hill-Burton program income qualification guidelines:

100% of poverty level -----100% discount  
200% above poverty level ----- 50% discount  
300% above poverty level ----- 30% discount  
400% above poverty level ----- 10% discount

The patient will receive notice as to the approval or denial of Financial Assistance/Charity Care. The patient will also be instructed to call Hardin County General Hospital for further information on payment plans.





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**LIST OF MONTHLY EXPENSES**

Rent or House Payment	
Car Payment	
Loan Payment	
Loan Payment	
Doctor Payment	
Other Hospital Payments	
Phone	
Cable Vision	
Water	
Lights, heat or air	
Food	
Gas (car)	
Other expenses	
Insurance (car)	
Insurance (home)	
Insurance (accident)	
Credit Card Payments	
<b>TOTAL</b>	

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**LIST OF ASSETS AND ESTIMATED VALUE**

Home	
Property/ Land	
Automobile(s)	
Recreation Vehicle(s)	
Stock/Bonds	
Checking/ Savings Accounts	
<b>TOTAL</b>	

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Patient's Signature

Today's Date

I believe the information provided for this application is true to the best of my knowledge. I furthermore agree that hospital has taken steps to assist me/ and or my family following policy and Federal Poverty Guidelines.

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Witness to Patient's Signature

Date