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**UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS  
MANAGEMENT POLICY AND PROCEDURE**

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**NO.: LD 3.07**

**APPROVAL DATE: May 30, 2024**

**EFFECTIVE DATE: June 5, 2024**

**SUBJECT: Financial Assistance Policy for Illinois Patients**

**OBJECTIVE**

The purpose of this policy is to define the hospital financial assistance policy specifying how the University of Illinois Hospital & Clinics (Hospital) will determine the financial liability for emergency and other medically necessary services rendered to patients and to specify how the Hospital will determine and apply available financial assistance discounts for services provided to patients.

**DEFINITIONS**

**Amounts Generally Billed/Amounts Generally Billed Discount:** The discount required to ensure that charges for care for Emergency Medical Conditions or other Medically Necessary care provided by the Hospital during an outpatient visit or inpatient stay to individuals eligible for assistance under this policy are not more than amounts generally billed to individuals who have Medicare or commercial insurance covering such care (“Amounts Generally Billed”).

**Charity Care:** Medical care for which the likelihood of payment of charges in full from patient, family or third-party source is not anticipated (210 ILCS 76/10 – Community Benefits Act).

**Emergency medical care:** Medical care which (in the professional judgment of the applicable provider), if not rendered, would result in a serious threat to health, risking the occurrence of a significant disability or loss of life (within 24 hours).

**Extraordinary Collection Action (ECA):** Those actions that the Hospital may only take against an individual related to obtaining payment of a bill for care after reasonable efforts have been made to determine whether the individual is eligible for financial assistance. Such ECAs are further defined in this policy.

**Federal Poverty Level:** The poverty guidelines which are updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

**Financial Plan:** Any one or a combination of the following to assure payment of charges:

- Adequate and verifiable insurance or other third-party coverage assigned to the Hospital by an authorized person.
- A guarantor of account acceptable to the Chief Financial Officer, or designee.
- The willingness of the patient and/or family (or representative) to apply for medical assistance programs (including grants and other sources of funding).
- The willingness of the patient and/or family (or representative) to apply for third party

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coverage available through the Affordable Care Act.

- A satisfactory repayment agreement by the patient, family and/or representative to pay the Hospital charges; or
- Review and approval of eligibility for charity care, in whole or in part.

**Gross Charges:** The full, established price for medical care that the Hospital consistently charges patients before applying any contractual allowance, discounts, or deductions. This is also the level of charges for services that the Hospital sets in order to allow its revenue budget to exceed its expense budget, given payment by many payers at levels insufficient to recover full costs for those payers' patients. Charges include co-pays and deductibles.

**Illinois Resident:** Any person who lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving healthcare benefits does not satisfy the residency requirement.

**Insured Patient:** A patient who has third-party coverage from a health insurer, a health care service plan, Medicare or Medicaid, or whose injury is compensable for purposes of workers' compensation, accident liability insurance, third party liability, or other insurance as determined and documented by the Hospital (210 ILCS 88/10 – Fair Patient Billing Act, *see also* 210 ILCS 89/5 – Hospital Uninsured Patient Discount Act).

**Medically necessary service:** Any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. Medically necessary services do not include any of the following: (1) non-medical services such as social and vocational services; and (2) services deemed not medically necessary, such as elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.

**Non-emergent medical care:** Medical care which (in the professional judgment of the applicable provider), if not rendered, would present neither serious threat to a patient's health nor risk the occurrence of significant disability or loss of life.

**Patient:** An individual who is receiving medical care, treatment, or attention from healthcare professionals at the Hospital. In instances where the patient is a minor or unable to make decisions for themselves, the responsible party and/or representative may be considered the patient.

**Plain Language Summary:** A clear, concise, and easy-to-understand written statement that notifies an individual that the Hospital offers Financial Assistance and provides the following information: (i) brief description of the eligibility requirements and assistance offered under this policy; (ii) a brief summary of how to apply for assistance under this policy; (iii) a direct listing of a website address (or URL) and physical locations (including room numbers) where a copy of this policy and Financial Assistance Applications may be obtained; (iv) instructions on how to obtain a free copy of the Financial Assistance Policy and Application by mail; (v) contact information (including telephone numbers and physical location, if applicable) of offices or departments who can provide an individual with assistance with the Application process; (vi)

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availability of translations; and (vii) a statement that no Financial Assistance-eligible Patient will be charged more than the Amounts Generally Billed.

**Presumptive Eligibility:** Criteria by which an uninsured patient's financial need is determined and used to deem a patient eligible for hospital financial assistance without further scrutiny.

**Self-Pay Package Priced Services:** Multiple services offered together for a single price which is discounted such that the single price is less than the sum of the prices for all the individual services comprising the package of services.

**Uninsured Patient:** A patient who does not have third-party coverage from a health insurer, a health care service plan, Medicare or Medicaid, and whose injury is not compensable for purposes of workers' compensation, accident liability insurance, third party liability or other insurance as determined and documented by the Hospital (210 ILCS 88/10 – Fair Patient Billing Act, see *also* 210 ILCS 89/5 – Hospital Uninsured Patient Discount Act).

## **POLICY**

As part of the Hospital's mission to improve the health of our patients and communities, we offer several financial assistance programs to help patients with their health care costs for medically necessary or emergent services. The Hospital is committed to ensuring that all uninsured patients, and insured patients who request it, are screened for Financial Assistance at the earliest reasonable moment and educated on their financial options. At the Hospital, all patients are treated with dignity regardless of their ability to pay.

This policy defines the guidelines and criteria to qualify for all components of the Hospital's Financial Assistance Programs. Any financial assistance awarded will be applied to the patient's responsibility for emergency or other medically necessary services only.

All discounts as described throughout this policy apply to all medically necessary services provided by University of Illinois Hospital & Clinics (Hospital) and the University of Illinois at Chicago Physicians Group associated with services provided at Hospital and its provider-based clinics. Any excluded providers are referenced in Addendum 1 to this policy. All discounts described under this policy exclude items considered to be Self-Pay Package priced services which are already discounted. If a self-pay package discount applies, the patient eligible for financial assistance under this policy will be asked to pay the lesser of the AGB or a patient package price. In addition, Financial Assistance for transplants and transplant-related services are not covered by this policy.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code, the Illinois Hospital Uninsured Patient Discount Act ("Discount Act") and the Illinois Fair Patient Billing Act ("Billing Act") and the regulations promulgated thereunder and must be interpreted and applied in accordance with those laws and regulations. The Chief Financial Officer has established requirements related to qualifications for application and related discounts under this policy. The Associate Chief Financial Officer, Revenue Cycle shall be responsible for implementing the policy according to the requirements.

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This Policy describes:

- The definitions for terms used throughout the policy.
- The eligibility criteria for financial assistance, and whether such assistance includes free or discounted services.
- The basis for calculating amounts charged to patients.
- The financial assistance application method.
- The collection actions the Hospital may take in the event of non-payment, including civil collections actions and reporting to consumer credit reporting agencies for patients that qualify for financial assistance.
- The Hospital's approach to presumptive eligibility determinations and the types of information that it will use to assess presumptive eligibility; and
- The Hospital's approach to Financial Assistance screening for all uninsured patients includes the types of information that it will use to assess eligibility for public health insurance, charity care and/or applicable discounts.

The Hospital will comply with all federal, state, and local laws, rules, and regulations applicable to the conduct described in this policy. If the provision of financial assistance becomes subject to additional federal, state, or local law requirements, and those laws impose more stringent requirements than are described in this policy, then those laws will govern how the Hospital administers its financial assistance program. The Hospital shall file its annual Hospital Financial Assistance Report or other reports as required by statute or regulatory agency.

**A. Emergency Medical Care**

1. The Hospital shall provide, without discrimination, care for Emergency Medical Conditions to individuals regardless of whether they can pay for the care or are eligible for Financial Assistance. The Hospital shall not engage in actions that discourage individuals from seeking care for Emergency Medical Conditions, including but not limited to the following:
  - a) Requiring payment from an Emergency Department Patient before receiving a medical screening or treatment for Emergency Medical Conditions; or
  - b) Permitting debt collection activities in the Emergency Department or in other areas of the Hospital where such activities could interfere with the provision, without discrimination, of care for Emergency Medical Conditions.

Reference policy [TX 5.13 Emergency Medical Treatment and Active Labor Act \(EMTALA\)](#) for more information on Emergency Medical Care.

**B. Eligibility Criteria for Financial Assistance Programs**

1. Hospital financial assistance programs available to uninsured patients include Charity Care, Catastrophic Loss Claims, and the Uninsured Patient Discount (in accordance with 210 ILCS 89 – Hospital Uninsured Patient Discount Act).
2. Charity Care: Charity care assistance will generally be provided on a prospective basis unless there is evidence of a pending application for public aid and/or social security disability coverage at the date of the application. Patients or their guarantors wishing to apply for Charity Care are encouraged to submit a Financial Assistance Application within ninety (90) days of their discharge or outpatient service. Based on Financial Screening results, patients may be instructed to apply for public health insurance before

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submitting a charity care application. Patients or their guarantors may submit a financial assistance application the greater of (1) two-hundred and forty (240) days after the first post discharge billing statement for the care that has been rendered or (2) 90 days from the date of denial for public health insurance. Charity care eligibility will be approved for a maximum of one year from the date of application at which time the patient must provide updated financial information for review to continue eligibility.

- a) Consideration for eligibility of Charity Care will be based on application of the following criteria:
- 1) The patient is an uninsured patient as defined by this policy; and
  - 2) The patient is an Illinois resident at the time of application; and
  - 3) The patient is a legal resident of the United States; and
  - 4) The patient is receiving, scheduled to receive, or has received a medically necessary service as defined and not otherwise excluded by this policy; and
  - 5) The patient has a family income less than 400% of the federal poverty level guidelines; and
  - 6) The patient satisfies the requirements of Patient Responsibilities under this policy, OR
  - 7) A presumptive eligibility determination is made, OR
  - 8) The patient is not a legal US resident, but otherwise satisfies criteria 1, 2, 4, 5 and 6 above and has received emergency room or inpatient services at the Hospital requiring post discharge specialty care or has received a screening service referred to and provided by the Hospital covered through a grant of which the outcome necessitates additional continued specialty care.
- b) If the uninsured patient satisfies the requirements established by the Hospital to qualify for Charity Care and the family gross income of the uninsured patient is less than or equal to:
- 1) 0 to 200% of the federal poverty level, the charity care discount is equal to 100% from full charges (bill is completely discounted).
  - 2) 201 to 300% of the federal poverty level, the charity care discount is equal to 90% from full charges.
  - 3) 301 to 400% of the federal poverty level, the charity care discount is equal to 80% from full charge.
- c) Insured patients, including patients who are out of network or are covered by an insurance program at another provider or facility, are not eligible for financial assistance under this policy. For those patients who are insured, but nevertheless lack the financial resources to pay for their health care services, the Hospital may, at its sole discretion, provide financial assistance to those who otherwise meet eligibility criteria under this policy. Insured patients must request financial assistance.

**C. Catastrophic Loss Claims**

Uninsured patients, as defined by this policy, who qualify for Charity Care, are also eligible for additional discounts based on the total dollar amount of the claim calculated at gross charges. This provision applies to patients who do not qualify for a 100% discount and are required to pay 90%, 80% or another portion of the hospital charges. The claim must be catastrophic as an individual claim for any patient that has a balance after applicable discounts that exceeds \$50,000. The catastrophic claim provision identifies a maximum amount payable based on a percentage of annual gross income. Payment on the

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catastrophic claim will not exceed 20% of the patient's annual gross income. The amount payable becomes the lesser of the regular charity discounts or the catastrophic loss provision. The additional discount, if applicable, will be identified as charity. The patient must request additional discounts available under this provision by contacting a representative from a billing office as referenced in Addendum 3.

**D. Uninsured Patient Discount**

The Uninsured Patient Discount is designed to provide uninsured patients who meet certain requirements with a discount from standard hospital charges. This provision applies to all hospitals licensed in the State of Illinois and normalizes the ultimate cost of care across all facilities. The Uninsured Patient Discount must be requested for each individual encounter or visit (as provided below).

1. Consideration for eligibility of the Uninsured Patient Discount will be based on application of the following criteria:
  - a) The patient is an uninsured patient as defined by this policy; and
  - b) The patient is/was an Illinois resident when care was rendered; and
  - c) The patient has received a medically necessary service as defined and not otherwise excluded by this policy; and
  - d) The patient has requested a discount within 240 days of the first post discharge billing statement for the care rendered; and
  - e) The patient has a family income less than 600% of the federal poverty level guidelines; and
  - f) The patient satisfies the requirements of Patient Responsibilities under this policy.
2. If the uninsured patient satisfies the requirements established by the Hospital to qualify for the Uninsured Patient Discount and the family gross income of the uninsured patient is less than or equal to:
  - a) 0 to 200% of the federal poverty level, the Uninsured Patient Discount is equal to 100% from full charges (bill is completely discounted).
  - b) 201 to 600% of the federal poverty level, the Uninsured Patient Discount shall be minimally consistent with the cost-based discount established by the Uninsured Patient Discount Act (UPDA) and must also comply with the federal 501(r) requirement of amounts generally billed (AGB). The discount may change annually based on the hospital's cost report and analysis of AGB. The discount amount will be the greater of the UPDA cost based discount or the AGB discount – whichever amount provides the greatest level of discount to the uninsured patient for services covered under this policy.
  - c) The Hospital may extend the Uninsured Patient Discount to those with a family gross income of more than 600% of the federal poverty level, on a case-by-case basis.
3. The current discount applicable to the Uninsured Patient Discount and AGB Discount for federal poverty levels 201 to 600% as discussed in this section of the policy is referenced in Addendum 2 of this policy.
4. If the uninsured patient satisfies the requirements established by the Hospital for both Charity Care and the Uninsured Patient Discount under this policy, the uninsured patient may request the highest percentage discount available under this policy and based on federal poverty levels.
5. To be eligible to have the Uninsured Patient Discount applied to subsequent charges, the uninsured patient must inform the Hospital in subsequent encounters that the patient

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has previously received health care services from the Hospital and was determined to be eligible for the Uninsured Patient Discount financial assistance program under this policy.

**E. Presumptive Eligibility**

1. An uninsured patient will be deemed presumptively eligible for the highest level of Charity Care Discount if the patient demonstrates one or more of the following:
  - a) Homelessness.
  - b) Deceased with no estate.
  - c) Mental incapacitation with no one to act on patient's behalf.
  - d) Medicaid eligibility, but not on date of service or for non-covered service.
  - e) Enrollment in the following assistance programs for low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:
    - 1) Women, Infants and Children Nutrition Program (WIC).
    - 2) Supplemental Nutrition Assistance Program (SNAP).
    - 3) Illinois Free Lunch and Breakfast Program.
    - 4) Low Income Home Energy Assistance Program (LIHEAP).
    - 5) Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership.
    - 6) Receipt of grant assistance for medical services.
2. In addition to the categories above, an uninsured patient may be deemed Presumptively Eligible based on information available to the Hospital. If the uninsured patient is deemed presumptively eligible, the applicable Charity Care Discount will be applied as soon as possible after receipt of health care services and prior to the issuance of any bill for those health care services, if the information is available to the Hospital prior to billing. Information sources used to identify presumptive eligibility include a financial assistance application, information to substantiate one of the presumptive eligibility categories, eligibility, or other data sources available to the Hospital. To assure the Hospital's ability to apply the Charity Care Discount as soon as possible after services have been received by the patient and before the issuance of such bill, the patient must provide notice to the Hospital of Presumptive Eligibility. To the extent such eligibility information is available without patient notice; the Hospital shall use such information to apply Presumptive Eligibility. The Hospital will also apply Presumptive Eligibility for services in situations where the patient provides notice and supporting documentation after billing has commenced.

The cost of care on discounts established under the Uninsured Patient Discount will be identified as charity.

**F. Calculating Amounts Charged to Patients**

1. Discounts may vary between Financial Assistance Programs. However, in all Financial Assistance Programs, amounts charged by the Hospital for care for Emergency Medical Conditions or other Medically Necessary care as defined by this policy provided to individuals eligible for the Financial Assistance Program with annual household income less than or equal to 600% of the applicable Federal Poverty Level shall not be more than the amounts generally billed to individuals who have insurance covering such care

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("Amounts Generally Billed Discount").

2. The Hospital determines the amount generally billed (AGB) for patients covered under this policy by multiplying its charges for any emergency or other medically necessary care it provides by certain percentages using the Internal Revenue Service look-back method as described in Treas. Reg. §1.501(r)-5. The look back method analyzes a recent 12-month period of allowed claims to determine the actual payment rate that Medicare and private insurers are collectively allowing. The intent is to ensure that the discount provided to financial assistance eligible patients is equal to or greater than the discount provided to patients with insurance. Patients can learn more about this calculation or request a written explanation of the method used by contacting a Financial Counselor with contact information listed in Addendum 3 of this document. The current discount applicable to the Amounts Generally Billed Discount as discussed in this section of the policy is referenced in Addendum 2 of this policy.
3. Under Illinois law, the maximum amount the Hospital can collect from uninsured patients as defined by this policy is 20% of family income, looking across a twelve-month collection period. The 12-month period to which the maximum amount applies begins on the first date an uninsured patient receives services from the Hospital that are determined to be eligible for assistance under this policy.

**G. Applying for Financial Assistance**

The Hospital is committed to assisting patients in further understanding Financial Policies and in application for potential third party programs to offset the costs related to medically necessary services, see [LD 1.01 Mission, Vision and Values, –University of Illinois Hospital & Clinics](#). The Hospital will make reasonable efforts to screen all uninsured patients for eligibility for public health insurance and any financial assistance programs offered by the Hospital. The Hospital will provide Financial Counselors to assist the patient in completing the application process for the program(s) the patient is best suited. Furthermore, patients who are deemed eligible for hospital financial assistance or public health insurance will not be steered into payment plans or sent to collections except for amounts due as determined through cost sharing or financial assistance discounts where applicable.

**H. Patient Responsibilities**

This policy requires the cooperation of the patient as a condition of receiving assistance; see [RI 2.01 Patient's Rights and Responsibilities](#). That cooperation includes, but is not limited to, the following:

1. The patient must cooperate with the Hospital by providing information on third-party coverage. If the Hospital finds that there is a reasonable basis to believe that the patient may qualify for such assistance, the patient must cooperate in applying for third-party coverage that may be available to pay for the uninsured patient's medically necessary care, including coverage from a health insurer, a health care service plan, Medicare, Medicaid, All Kids, Family Care, accident liability insurance, worker's compensation, third party liability, or other insurance available under the Affordable Care Act. If the patient declines to apply for a public health insurance program on the basis of concern for immigration-related consequences, the Hospital may refer the patient to a free, unbiased resource such as an Immigrant Family Resource Program to address the patient's immigration-related concerns and assist in enrolling the patient in a public health



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insurance program. The hospital may still screen the patient for eligibility under its financial assistance policy.

2. If the patient is eligible for third party coverage, the patient must obtain and maintain coverage that may be available. Should the patient experience difficulty making premium payments required to maintain coverage, the patient should notify the Hospital immediately to discuss potential solutions or funding options.
3. Once an application has been submitted, the patient must provide the Hospital with financial and other information requested to determine eligibility for financial assistance. Information to support application materials must be received within 30 days of completion of the financial screening. Information provided by the patient should include identification of the applicant (for example, a state issued ID card), earned income, including monthly gross wages, salary and self-employment income; unearned income including alimony, child support, retirement benefits, dividends, interest and income from any other source; number of dependents in household; number of dependents in household based on the Federal tax return; and other information to determine the patient's financial status, including assets and liabilities. Supporting documentation such as payroll stubs, tax returns, credit history may be requested to support information reported and shall be maintained with the completed assessment. If the applicant does not have specific information to support household income or household size, the applicant should contact a financial counselor as identified in Addendum 3 to discuss what other information may be submitted to support the application.
4. Generally, the patient or a person acting on their behalf must request assistance from the Hospital. Although, the Hospital has full discretion to identify specific cases for potential charity needs based on financial and other information that is made available to the organization.
5. The patient who has a payment obligation, after any applicable discounts or Charity care to the Hospital must cooperate with the Hospital to establish and comply with a financial plan. The patient who enters into a financial plan agreement shall promptly inform the appropriate Hospital billing entity of any change in circumstances that will impair their ability to comply with the financial plan.
6. The patient must notify the Hospital of any change in financial status that could disqualify the patient for financial assistance.
7. Any patient who fails to satisfy their responsibilities under the Patient Responsibilities section of this policy may be billed by the Hospital and is subject to collection activities consistent with organizational billing and collection policies and practices for patients who do not qualify for assistance under this policy. Any patient who fails to comply with a financial plan may be billed and is subject to collection activities consistent with the hospital's billing and collection policies and practices for the portion of the bill remaining after any financial assistance discount has been applied.

**I. Application Process**

1. To apply for financial assistance, a patient must complete the Hospital's financial assistance application form. The individual will provide all supporting data required to verify eligibility, including supporting documentation verifying income. Copies of the financial assistance application and instructions are available online at <https://hospital.uillinois.edu/patients-and-visitors/financial-assistance>, by requesting a copy in person at any of the hospital's patient admission or registration areas, or by

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requesting a free copy by mail by contacting a Hospital financial counselor. See Addendum 3 for contact information.

2. Patients or their guarantors wishing to apply for Financial Assistance are encouraged to submit a Financial Assistance Application either prospectively or within ninety days (90) days of their discharge. Patients will have 30 days from the application date to turn in all required documentation. If the patient fails to submit the required documentation within the 30-day timeline, the hospital will document the lack of received documentation, the date of the screening, and that the 30-day timeline has lapsed. Patients may reopen their application within 90 days from the completion of screening. Patients or their guarantors may submit an application up to two-hundred and forty (240) days from the date of their first post discharge billing statement from the Hospital.
3. Patients or their guarantors submitting an incomplete application will receive written notification of the application's deficiency upon discovery by the Hospital including information relating to what additional information is required and contact information for a financial counselor. The application will be pended for a period of 60 days from the date the financial screening is completed. The Hospital will suspend any Extraordinary Collection Action (ECA) defined in this policy until the application is complete, or the patient fails to cure any deficiencies in their application in the allotted period.

**J. Decision Process**

1. The Hospital will inform patients or guarantors of the results of their application by providing the patient or guarantor with a written Financial Assistance Determination within thirty (30) days of receiving a completed Application and all requested documentation. If a patient or guarantor is granted less than full charity assistance and the patient or guarantor provides additional information for reconsideration, the Hospital may amend a prior Financial Assistance Determination.
2. If a patient or guarantor seeks to appeal the Financial Assistance Determination further, a written request must be submitted, along with the supporting documentation, to the Financial Case Management Unit as identified in Addendum 3 for additional review/reconsideration by the Chief Financial Officer or Designee.

**K. University of Illinois Hospital and Clinics (Hospital) Billing and Collections Responsibilities**

1. The Hospital will make efforts at the earliest reasonable moment to obtain from a patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered to the patient, including, but not limited to, health insurance, a health care service plan, Medicare, Medicaid, All Kids, family Care, accident liability insurance, workers compensation, third party liability, or other insurance available under the Affordable Care Act.
2. All uninsured patients will be offered a financial screening to determine potential eligibility for public health insurance programs and any financial assistance offered by the Hospital. Patients will be provided assistance with the application enrollment and/or completion process as needed.
3. The Hospital shall not initiate any Extraordinary Collection Action (ECA) before making reasonable efforts to determine whether a patient is eligible for public health insurance programs and/or financial assistance under the policy. The patient will be allowed 240 days following the date of first post discharge statement to complete financial screening

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or to agree to a payment plan. However, if the patient does not make adequate financial plans within 120 days of the date of the first post discharge statement, collection actions may begin. If an uninsured patient has agreed to a financial assistance screening from the Hospital and is cooperating with provisions identified under the Patient Responsibilities section of this policy, the Hospital or its assignee or billing service shall not pursue collection action against the uninsured patient until a determination is made on the uninsured patient's eligibility for public health insurance programs and/or financial assistance. If an uninsured patient complies with a financial plan that has been agreed to by the Hospital, the Hospital shall not otherwise pursue collection action against the uninsured patient.

4. The Hospital does not defer or deny care based on non-payment from prior bills.
5. The Hospital and its third-party collection agencies may initiate an Extraordinary Collection Action (ECA) against a patient or their guarantor in accordance with this Policy and 26 C.F.R. § 1.5011. ECAs may include the following:
  - a) Reporting adverse information about the patient or their guarantor to consumer credit reporting agencies or credit bureaus.
  - b) Actions requiring a legal or judicial process, including but not limited to:
    - 1) Commencing a civil action against a patient or their guarantor
    - 2) Garnishing a patient or guarantor's wages
  - c) Offsetting other payments owed the patient or guarantor by the State of Illinois through the Comptroller Offset System
6. When it is necessary to engage in such action, the Hospital, and its collection agencies, will engage in fair, respectful and transparent collections activities. Before engaging in, or resuming, any of the extraordinary collection actions (except the deferral or denial of care for non-payment of amounts for previous care), the Hospital will issue a written notice that (i) describes the specific collection activities it intends to initiate (or resume), (ii) provides a deadline after which such action(s) will be initiated (or resumed), and (iii) includes a plain-language summary of this policy. Related to the initiation of the ECA, the Hospital will also make a reasonable effort to orally notify the patient about the financial assistance policy and how the patient can request assistance with the application process. The Hospital may initiate collection activities no sooner than 30 days from the date on which it issues the ECA Initiation Notice, either by mail or electronic mail (if so, authorized by the patient/guarantor).

Patients or guarantors currently subject to an ECA who have not previously applied for Financial Assistance may apply for assistance up to 240 days of the date of their first post discharge billing statement from the Hospital. The Hospital and its third-party collection agencies will suspend any ECA engaged on a patient or their guarantor while an application is being processed and considered. If the application is approved, the prior ECA will be reversed.

#### **L. Refunds**

Patients eligible for assistance under this Policy who remitted payment to the Hospital in excess of their patient responsibility for care included in the Application will be alerted to the overpayment as promptly after discovery as is reasonable given the nature of the overpayment. Patients with an outstanding account balance due to any the Hospital entity on a separate account not eligible for assistance under this Policy will have their refund applied to the outstanding balance. Patients without an outstanding account balance described above will be issued a refund for their overpayment as soon as technically

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feasible as required by law.

**M. Confidentiality**

The Hospital respects the confidentiality and dignity of its patients and understands that the need to apply for financial assistance may be a sensitive issue. The Hospital staff will provide access to financial assistance related information only to those directly involved with the determination process and will comply with all HIPAA requirements for handling personal health information.

**N. Publicizing the Policy**

The Hospital will widely publicize its financial assistance program within the community it serves. To that end, the Hospital will take the following steps, among other actions determined appropriate by the Hospital from time to time, to ensure that members of the community are aware of the program and have access to this policy and the related documents.

1. The Hospital will make a copy of this Policy available to the community by posting it online at <https://hospital.uillinois.edu/patients-and-visitors/financial-assistance> along with downloadable copies of the financial assistance application, and a plain language summary of this Policy.
2. The Hospital will make paper copies of the Financial Assistance Policy (FAP), the FAP application form and plain language summary of the FAP available upon request and without charge, on the hospital website, by mail and in the emergency room and admission/ registration areas in the Hospital to any member of the public or regulatory agencies.
3. The Hospital will notify and inform members of the community about this policy and how or where to obtain more information about the policy and application process as well as copies of materials. Notification shall be in a manner reasonably calculated to reach those members of the community who are most likely to require Financial Assistance from the Hospital. Patient services, including the initial screenings and all follow-up assistance, will be provided in compliance with the Language Assistance Services Act, see RI 2.02 Language Services for Limited English Proficient (LEP) and Hearing Impaired.
4. The Hospital shall notify and inform individuals who receive care from the hospital about the financial assistance program by:
  - a) The Hospital will offer a paper copy of the plain language summary of the financial assistance program to patients as a part of the intake or discharge process. The Hospital may provide any written notice electronically to any individual who indicates they prefer to receive communications electronically.
  - b) Each billing statement for self-pay accounts will include a conspicuous written notice about the Financial Assistance Program including contact information on how to apply for financial assistance as well as the direct website for the financial assistance program.
  - c) The Hospital will notify and inform visitors about this program through conspicuous public displays in places designed to attract visitors' attention.
5. The financial assistance policy, financial assistance application and plain language summary of the financial assistance policy shall be in English and translated in any other language that is the primary language of the lesser of 1000 individuals or 5 percent of

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the community served by the Hospital or the population likely to be affected or encountered by the Hospital.

**PROCEDURE**

**A. Application Process Description**

1. The registrar will determine patient financial status (including the presence of an existing financial plan) at the earliest reasonable moment in accordance with EMTALA regulations, see [TX 5.13 Emergency Medical Treatment and Active Labor Act](#) (EX: during scheduling, time of service, after stabilizing treatment etc.) If the patient is uninsured, the patient will be informed of their right to a financial screening.
  - a) Insured patients may request a financial screening prospectively and are encouraged to request a financial screening within 90 days of discharge. Insured patients have up to 240 days from the date of the first post discharge billing statement to apply for assistance.
2. Uninsured patients who do not already have a financial plan will be referred to a Financial Counselor for a financial screening.
3. If a Financial Counselor determines that a patient may be eligible for public health insurance, the patient will be instructed to apply for public health insurance. Assistance will be provided with the application process as needed.
  - a) If the patient declines to apply for public health insurance based on immigration related concerns, the patient may be referred to a free unbiased resource to address concerns and assist in enrolling.
  - b) If the patient's application for public health insurance is denied, the hospital shall offer to screen the patient for financial assistance, at which time, the 90-day timeline shall begin again.
4. If a financial counselor determines that a patient may be eligible for charity care, the patient will be provided with an application. Assistance will be provided with the application process as needed. The completed application and all supporting documents are due 30 days from the date of the screening.
  - a) Supporting documentation includes but is not limited to: Photo ID, proof of income, tax returns, and paystubs.
  - b) If the patient fails to turn in a completed application with supporting documents within the 30-day timeline, the hospital shall document the lack of received documentation, the date of the screening, and that the 30-day timeline has lapsed. Patients may reopen their application within 90 days after the completion of financial screening. Patients have up to 240 days from the date of the first post discharge billing statement to apply for assistance.
5. Financial Counselors will review completed applications and inform patients of the results of their application in writing within 30 days of receipt.
6. Upon approval for Financial Assistance, the Hospital will review all services rendered and apply discounts where applicable.
7. If a financial assistance application is denied, the patient may be asked to develop a financial plan in accordance with [LD 3.06 Deposits for Elective Non-emergent Medical Care](#).
  - a) Patients may appeal the Financial Assistance Determination by submitting a

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written request, along with all supporting documentation to the Financial Case Management Unit for reconsideration.

**Key Words:** none

**References**

**Hospital Management Policy and Procedures**

[LD1.01 Mission, Vision and Values, University of Illinois Hospital & Clinics](#)

[RI 2.01 Patient Rights and Responsibilities](#)

[TX 5.13 Emergency Medical Treatment and Active Labor Act \(EMTALA\)](#)

[LD 3.06 Deposits for Elective Non-emergent Medical Care](#)

[RI 2.02 Language Services for Limited English Proficient \(LEP\) and Hearing Impaired](#)

Illinois Hospital Uninsured Patient Discount Act [210 ILCS 89/]

Illinois Fair Patient Billing Act [210 ILCS 88/]

Internal Revenue Code Section 501(r)

Social Security Act [42 U.S.C. 1395dd]

Language Assistance Services Act [210 ILCS 87]

**Addenda**

Addendum 1: Financial Assistance Policy Excluded Providers

Addendum 2: Discount related to the UI Hospital financial assistance program applicable to the Uninsured Patient Discount and Amounts Generally Billed Discount

Addendum 3: Financial Assistance Policy Contact Information

**Rescission Date**

January 2022

November 2020

July 2019

March 2019

September 2018

January 2018

October 2017

July 2016

January 2014

November 2012

November 2009

March 2007

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December 2004

**Reviewed by**

This policy was reviewed and endorsed by the following individuals:  
Chief Financial Officer

**Policy Owner** - Associate Chief Financial Officer, Revenue Cycle

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**Addendum 1: Financial Assistance Policy Excluded Providers**

All discounts described throughout this policy apply to all medically necessary services defined by this policy provided by the University of Illinois Hospital and the University of Illinois at Chicago Physicians Group associated with services provided at the University of Illinois Hospital and its provider-based clinics.

The billing practices and discounts associated with UI Hospital's Financial Assistance Program provided at the University of Illinois Hospital and its provider-based clinics may not apply to all physicians, physician departments or services. Therefore, any professional or other fees associated with those providers would be excluded from the policy.

The providers not covered by this policy be can be found under "Important Documents" located at the following link: <https://hospital.uillinois.edu/patients-and-visitors/financial-assistance>. This information may also be requested by contacting 312-996-1000. The excluded list shall be reviewed and updated at least quarterly.



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**Addendum 2: Discount related to the UI Hospital financial assistance program applicable to the Uninsured Patient Discount and Amounts Generally Billed Discount**

0-200% FPL = 100% Discount from charges  
201 – 600% FPL = 70% Discount from charges

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**Addendum 3: Financial Assistance Policy Contact Information**

Website: <http://hospital.uillinois.edu/patients-and-visitors/patient-information/financial-assistance>

**For Financial Assistance Questions, please contact:**

Financial Case Management Unit  
University of Illinois Hospital  
1740 W. Taylor Street, Room 1155 (M/C 778)  
Chicago, IL 60612-7232  
Telephone: 312-413-7621  
Fax: 312-413-3371  
Email: [getinsured@uic.edu](mailto:getinsured@uic.edu)

**For Billing Questions, please contact:**

University of Illinois Hospital or University of Illinois Physicians Group  
C/O Wolcott, Wood and Taylor, Inc.  
200 W. Adams, Suite 225  
Chicago, IL 60606  
Telephone: 312-996-1000  
Fax: 312-667-7392  
Email: [billinfo@uic.edu](mailto:billinfo@uic.edu)  
(Wolcott, Wood and Taylor, Inc. provides billing related support for the above entities, except the Department of Pathology)

University of Illinois Physicians Group  
Department of Pathology  
C/O AdvantEdge Healthcare Solutions, Inc.  
30 Technology Drive  
Warren, NJ 07059  
Telephone: 877-501-1611

For Pathology services rendered before 07/01/2023:

University of Illinois Physicians Group  
Department of Pathology  
C/O Kellison & Company  
4925 Galaxy Parkway, Suite U  
Cleveland, OH 44128  
Telephone: 888-694-6300  
Email: [info@kellison.com](mailto:info@kellison.com)