

SUMMARY OF ADVOCATE HEALTH CARE's CHARITY CARE POLICY¹

It is the policy of Advocate Health Care to provide financial assistance to patients in need. Advocate hospitals will extend medically necessary services free-of-charge, or at a reduced amount, to an individual who is eligible under the following criteria. This summary applies to patients of Advocate Hospitals (i) who have no private health insurance or public health coverage (such as Medicare, Medicaid or other government programs) or (ii) whose co-payments and deductibles equal or exceed \$5,000 in a calendar year.

Charity Care decisions are based on the family's "gross income," which means gross earnings reportable to the federal government. A patient whose family's gross income does not exceed four times the Federal Poverty Level ("FPL") qualifies for Charity Care. The FPL varies with the size of the family and is updated annually. For example, as of January 23, 2008, a family of four may be eligible for Charity Care if its household income is less than \$84,800 per year. You may also be granted Charity Care if your family income is higher than four times FPL if you can show extenuating financial circumstances (such as large outstanding medical bills).

The following table will be used to make the Charity Care determinations:

Multiple of FPL	0 - 1	1 - 2	2 - 3	3 - 4
Expected Payment	\$0	\$0	Hospital's Cost of Services Provided	Hospital's Cost of Services Provided
Maximum Expected Payment	\$0	\$0	5% of Income	10% of Income

To qualify for Charity Care, you must complete the attached application form and mail or deliver it to the Advocate Hospital where you were treated. All communications with the patient or family members will be handled in strict confidence and in a compassionate manner. The application requires you to certify your family's current monthly income, and provide proof in the form of W-2 forms, tax return or pay stubs if available. If you cannot provide such documents, the determination will be based on your certification of your family's income. It is your responsibility to cooperate with Advocate by filling out the application and providing the requested information if possible, and also by helping Advocate seek payment from health insurers or the government if such payment might be available. While your application for Charity Care is pending, Advocate will not try to collect the bills for which you are seeking assistance.

If you apply for Charity Care, the Advocate Hospital will notify you whether your application has been approved or denied. If you disagree with Advocate's decision, you may appeal the decision to the Ombudsperson within 45 days. The Ombudsperson is Kathleen Hobbins and can be reached at (630) 575-3446. You may also contact the Ombudsperson if you have questions about the Charity Care process, or you may contact the Advocate Hospital's financial counselors at **630-275-4011**.

Return you completed application and documents to the hospital at the following address:

**Advocate Good Samaritan Hospital
 Attn: Business Office / Charity Coordinator
 3815 Highland Avenue
 Downers Grove, IL 60515**

¹ This is a summary created pursuant to a settlement agreement in *Cristiani v. Advocate Health Care* and applies only to patients covered by that agreement. If there are any differences between this summary and the settlement agreement, the terms of the settlement agreement control. This summary does not guarantee or grant any third party or person any rights, claims, benefits or privileges beyond those that may exist under the *Cristiani* settlement. This summary does not constitute an offer to any particular patient and creates no contractual rights or obligations

Charity Care Application
Patient Account Number(s): _____

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.						
PATIENT INFORMATION						
Last Name		First	M.I.	Age	Social Security Number	Family Size
Street	Apt. #	City	State	Zip Code	Home Phone	
Employer		Address			Cell Phone	
City	State	Zip Code	Monthly Income		Work Phone	
SPOUSE / (PARENT INFORMATION IF MINOR)				Relationship to Patient		Age
Last Name		First	M.I.	Social Security Number	Home Phone	
Employer		Address			Cell Phone	
City	State	Zip Code	Monthly Income		Work Phone	
INCOME INFORMATION						
Please provide one or more of the following for each employed family member and sign the statement below.						
1) a copy of most recent tax return 2) a copy of most recent W-2 and 1099 Forms 3) a copy of most recent pay stub						
If you cannot provide any documentation relating to your income, fill out the statement below:						
I, _____ (name), certify that I have no documents that prove my family's monthly income of \$ _____. I understand that if the above information is untrue, any charity granted to me may be forfeited, future requests may be denied and I will be responsible for payment of the hospital bill.						

OTHER INFORMATION

If you have additional documents that may help Advocate make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: phone bills, electricity bills, medical bills, bank or checking statements, etc....)

APPLICANT CERTIFICATION: I certify that the above information is true and complete to the best of my/our knowledge. I understand that as part of the financial screening process, my/our address, employment and credit history may be verified. I authorize Advocate to obtain copies of my tax returns from the Internal Revenue Service and the Illinois Department of Revenue.

Applicant Signature: _____

Date: _____

 If you have any questions regarding your application please call the Financial Counselor at **630-275-4011**.