SUMMARY OF STREAMWOOD BEHAVIORAL HEALTH CENTER CHARITY CARE POLICY

It is the policy of Streamwood Behavioral Health Center to provide financial assistance to patients in need. Streamwood Behavioral Health Center will extend medically necessary services free-of-charge, or at a reduced amount, to an individual who is eligible under the following criteria.

Charity Care decisions are based on the family's "gross income," which means gross earnings reportable to the federal government. An uninsured patient whose family's gross income does not exceed six times the Federal Poverty Level ("FPL") may qualify for Charity Care. The FPL varies with the size of the family and is updated annually. You may also be granted Charity Care if you can show extenuating financial circumstances (such as large outstanding medical bills).

To qualify for Charity Care, you must complete the attached application form and mail or deliver it to Streamwood Behavioral Health Center 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 Streamwood Behavioral Health Center by filling out the application and providing the requested information if possible, and also by helping Streamwood Behavioral Health Center seek payment from health insurers or the government if such payment might be available. While your application for Charity Care is pending, Streamwood Behavioral Health Center will not try to collect the bills for which you are seeking assistance.

If you apply for Charity Care, Streamwood Behavioral Health Center **will notify you** whether your application has been approved or denied. If you disagree with Streamwood Behavioral Health Center s decision, you may appeal the decision within 45 days.

You may also contact the hospital's financial counselor for assistance with your application, questions and appeal status at **630-540-4295**

Return your completed application and documents to the hospital at the following address, please:

Streamwood Behavioral Health Center
Attn: Business Office / Financial Counselor
1400 E. Irving Park Road
Streamwood, IL 60107

If you have previously submitted a charity care application in the past 45 days and would like to know the status, please call the Financial Counselor at the phone number on your bill. You do not need to submit another charity care application at this time.

Streamwood Behavioral Health Center

Charity Care Application **Patient Account Number(s): _____**

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.

PATIENT INFORMATION:

Email Address:							
Last Name	First	M.I.	Date of Birth	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		Date of Birth	
Email Address							
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 form
3) A copy of most recent pay stub

If you cannot provide any documentation relating to income, please complete 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.

Please list the dependents you are responsible for supporting. This number should agree with the number of dependents listed on your Income Tax Return.

Names of Dependents	**Date of Birth**	**Relationship**

Monthly Obligations

Mortgage/Rent	$	Car Maintenance	$
Food	$	Prescriptions	$
Clothing	$	Medical Bills	$
Phone	$	Union Dues	$
Cell Phone	$	Child Care	$
Electric	$	Life Insurance	$
Water	$	Auto Insurance	$
Other	$	Total Expenses	$

Please attach copies of the following documents:

1. If employed within the last 12 months, include a copy of:
   - Three (3) most recent pay stubs (applicant and spouse) from all employers (indicate if paid weekly or bi-weekly)
   - Most recent year's income tax return, including W-2 tax statement(s)
2. If self-employed, include:
   - Complete documentation of revenue and business-related expenses for the last six months (including a profit/loss statement)
   - Most recent year's income tax return (including Schedule C)
3. Proof of other income: i.e. social security, disability, pensions, unemployment and/or child support for the last three months
4. Bank statements for the last three months, including checking, savings, CDs, money market
5. Current mutual funds/stocks/bonds statements
6. If you have been unemployed or have earned little income over the past year, a written statement from the person or persons providing financial support to you is required
7. Copy of your electric bill for proof of Illinois residency

Other Information: If you have additional documents that may help Streamwood Behavioral Health Center 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 Information: I certify that the above information is true and complete to the best of my/our knowledge. I will apply for any state, federal or local assistance for which I may be eligible. I understand that as part of the financial screening process, my/our address, employment and credit history may be verified. I understand that if I knowingly provide untrue information, I will be ineligible for financial assistance and I will be responsible for the bill. I authorize [Hospital Name] to obtain copies of my tax returns from the Internal Revenue Service and the Illinois Department of Revenue.

Applicant Signature: _____ Date: _____

If you have submitted a charity care application in the past 45 days and would like to know the status of your application, Please call the Financial Counselor at 630-540-4295..

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

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