Advocate Health

Revised: 1/1/25

Financial Assistance Policy

Atrium Health, Aurora Health Care, Advocate Health Care and affiliates (collectively Advocate Health) are committed to caring for the health and well-being of all patients regardless of their ability to pay. Advocate Health is committed to assisting eligible patients in the communities we serve with obtaining coverage from various programs and extending financial assistance to those in need as outlined in this policy. This policy describes the procedure, requirements, and eligibility criteria related to Advocate Health's financial assistance programs.

Advocate Health offers coverage assistance and financial assistance to eligible individuals with the following objectives:

- Model Advocate Health's core value of "Caring."
- Ensure patients exhaust other coverage opportunities prior to qualifying for financial assistance.
- Provide financial assistance based on the patient's ability to pay.
- Ensure Advocate Health complies with applicable Federal and/or State regulations related to financial assistance.
- Establish processes that minimize the burden on patients and are cost efficient to administer.

Advocate Health will always provide emergency care regardless of the patient's ability to pay in compliance with Federal EMTALA regulations.

This policy applies to medical services billed by:

- An Advocate Aurora Health, Inc. entity or Participating Provider that has been provided by a Wisconsin Aurora Health Care hospital
- A Wisconsin Aurora Health Care employed medical professional
- A Wisconsin Participating Provider
- An Illinois Advocate Health hospital
- An Illinois Advocate Health employed medical professional or an Illinois Participating Provider
- An Atrium Health facility or the Atrium Health Medical Group

A list of facilities and provider groups who are not employed by Advocate Health and are not covered by the Advocate Health financial assistance policy can be found on our financial assistance web pages:

Atrium Health: https://atriumhealth.org/for-patients-visitors/financial-assistance
Advocate Health Care: http://www.advocatehealth.com/financialassistance
Aurora Health Care: http://www.aurorahealthcare.org/patients-visitors/billing-payment/financial-assistance

Definitions

The terms used within this policy are to be interpreted as follows:

Amounts Generally Billed (AGB): amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. Those eligible for financial assistance will never be billed more than the amounts generally billed to an insured patient. The AGB is calculated using the look-back method annually by averaging Medicare and all private third-party insurer allowed claims for medically necessary hospital services billed in a 12-month period. Information regarding AGB calculations may be requested by referencing the Advocate Health Billing and Collections policy online on the Advocate Health website or calling

Customer Service at 1-800-326-2250 for Wisconsin Aurora Health Care facilities and providers, 847-795-2300 for Illinois Advocate Health facilities and providers, and 704-512-7171 for Atrium Health facilities and providers.

Elective: services that, in the opinion of the ordering provider, are not needed, are cosmetic or can be safely postponed.

Eligible Patient: a patient that meets the Financial Assistance eligibility requirements provided in this policy.

Emergency Care: immediate care that is necessary in the opinion of a provider to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of organs or body parts.

EMTALA: Advocate Health shall provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they can pay for the care, or their eligibility under this Policy. Such care will be provided in accordance with the Federal Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Federal Poverty Guidelines (FPG): the applicable household income thresholds established periodically in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. §9902(2).

Financial Advocates/Financial Counselors: Advocate Health teammates that assist uninsured or insured patients by reviewing the patient's current financial situation to determine available coverage and financial assistance programs, assist those patients with enrollment in available programs, educate patients on the cost of care, and assist patients with overall management of patients' financial responsibility.

Financial Assistance Score (FAS Score): information provided by third-party vendors to provide a proactive, consistent, and automated mechanism to substantiate a patient's financial profile.

Generally Accepted Standards of Medical Practice: standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community including Physician Specialty Society recommendations, views of Physicians practicing in the relevant clinical area and any other relevant factors.

Household: the patient and any individuals (such as a spouse, children, or other dependents) who could be included on a federal income tax return regardless of whether the patient files a tax return.

Household Financial Income: the sum of all sources of income received in a 12-month period by certain individuals living in the household, including but not limited to:

- Annual household pre-tax job earnings.
- Unemployment compensation
- Workers' Compensation
- Social Security and Supplemental Security Income
- Veteran's payments
- Pension or retirement income
- Other applicable income, including for example, rents, alimony, child support and any other miscellaneous income regardless of source

Insured: patients who are insured and covered under a third-party insurer.

Medical Group: professional medical services provided by providers who are employed by Advocate Health.

Medically Necessary: healthcare services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are in accordance with the generally accepted standards of medical practice and/or clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.

Other Coverage Options: options that would yield a third-party payment on account(s) under coverage assistance and financial assistance review including, but not limited to: Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.

Participating Providers: independent health care providers who have agreed to comply with this Policy with respect to billable services provided at Advocate Health hospitals. Providers can be contacted directly to see if they are a Participating Provider.

Plain Language Summary (PLS): a summary of this Policy that is simplified to understand the eligibility criteria and how to apply for financial assistance.

Presumptive Eligibility: in compliance with state laws and regulations, a determination of financial assistance eligibility based on specific criteria which have been deemed to demonstrate financial need on the part of an uninsured patient without completion of a Financial Assistance application.

Third-party Insurers: any party ensuring payment on behalf of a patient, including insurance companies, workers' compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, or third-party liability resulting from automobile or other accidents. Health Cost Sharing plans including but not limited to MediShare are not considered a third-party insurer.

Self-Pay Balance: the portion of a patient's bill that the patient or the patient's guarantor is legally responsible for paying after any applicable discounts.

Uninsured Patient: a patient who is not covered in whole or in part under a third-party insurer and is not a beneficiary under a public or private health insurance, or other health coverage program (including, without limitation, private insurance, Medicare, Medicaid or Crime Victims Assistance) and whose injury is not compensable for purposes of worker's compensation, automobile insurance, liability or other third party insurance, as determined by Advocate Health based on documents and information provided by the patient or obtained from other sources, for the payment of health care services provided by Advocate Health.

Uninsured Patients

Uninsured patients will be reviewed for financial assistance though an automated process or the coverage assistance process completed by Advocate Health Financial Advocate/Financial Counseling teammates. Advocate Health Financial Advocates/Financial Counselors will review uninsured patients seeking assistance for other coverage opportunities prior to determining financial assistance eligibility.

Coverage Assistance Process

- Uninsured patients admitted to the hospital or who receive outpatient services resulting in a large balance will be interviewed by the Advocate Health Financial Advocate/Financial Counseling team. The interview consists of gathering information needed to assess the patient's eligibility for coverage options (i.e. Medicaid) as well as information needed to determine financial assistance eligibility.
- If uninsured patients are not interviewed prior to discharge, Advocate Health Financial Advocates/Financial Counselors will attempt to contact the patient to gather the information necessary to complete the interview. In addition, patients can initiate an interview by calling the number provided on correspondence from the Financial Advocate/Financial Counseling team, calling Customer Service or downloading an application and mailing it to the Financial Advocate/Financial Counseling team.
- If the coverage assistance process indicates a high likelihood that the patient will qualify for other coverage opportunities (i.e. Medicaid), then the patient, with assistance from the Financial Advocate/Financial Assistance team, will be required to pursue those coverage opportunities before the patient will be eligible for Advocate Health financial assistance.

- **If the patient fully cooperates through the process of pursuing coverage options**, but eligibility for such coverage is later determined to be unlikely or denied for reasons other than patient non-compliance, Advocate Health will then determine the patient's eligibility for financial assistance.
- **Uninsured patients who fail to fully cooperate with the coverage assistance process will be deemed ineligible for financial assistance**, which includes but is not limited to cooperating fully with the Financial Advocate/Financial Counseling team and state or federal agencies throughout the process of applying for Medicaid or other coverage options.
- Patients deemed ineligible for financial assistance due to failure to fully cooperate with the coverage assistance process may contact Customer Service to discuss payment options.

Coverage Assistance: Financial Assistance Eligibility Criteria

- Uninsured patients who reside in Illinois, Wisconsin[1], North Carolina, South Carolina, Georgia or Alabama.
- Uninsured patients receiving non-elective, medically necessary services at an Advocate Health facility or by an Advocate Health participating provider.
- Uninsured patients who fully cooperate through the process of determining and pursuing other coverage options (i.e. Medicaid)[2].
- Uninsured patients who are ineligible for all other coverage options for the account(s) under review.
- eligibility will be determined by comparing the patient's total household income to the Federal Poverty Guidelines (FPG) in effect at the time of review.
- Uninsured patients meeting all of the above criteria with a household income between 0% and 300% of the Federal Poverty Guidelines (FPG) are eligible for 100% financial assistance.
- Atrium Health patients: uninsured patients meeting all of the above criteria with a household income between 301% and 400% of the Federal Poverty Guidelines (FPG) are eligible for a 75% financial assistance discount off of gross total charges.
- Illinois patients ONLY: uninsured patients meeting all the above criteria with a household income between 301% and 600% of the Federal Poverty Guidelines (FPG) are eligible for a financial assistance discount per HUPDA[3] IL state regulatory requirements.

[1]uninsured patients who reside in the Michigan footprint near bordering Advocate Health facilities or Advocate Health participating providers.

[2] a patient confirmed to be a member of an established Plain Community or who has a belief system that prohibits their ability to cooperate with applying for insurance opportunities will have alternative options to the financial assistance programs outlined in this policy. This would include applying for a hardship settlement discount of which qualifying patients can receive up to a 75% discount off of the balance due.

[3] In compliance with the Illinois Hospital Uninsured Patient Discount Act (210 ILCS 89/1) (HUPDA) effective 4/1/09, eligibility for Financial Assistance for patients with Family income of four to six (4-6) times FPG is restricted to patients with Illinois residency and medically necessary charges. Advocate Health has compared the discounts for 135% of the hospital's cost to charge ratio to the AGB and have applied the more generous discounts for patients. Per HUPDA, the amount charged to a patient will be capped at 20% of the patient's gross annual income when the patient notifies Advocate Health of previous Financial Assistance approval within the past 12 months.

Financial Assistance Scoring (FAS)

Uninsured patients with low balance outpatient accounts will be evaluated automatically for financial assistance using third-party electronic screening tools.

- The third-party screening process identifies patients that meet the criteria for 100% financial assistance as outlined in this policy.
- Patients are not required to complete an application for services that are evaluated through the FAS process.

FAS Eligibility

- Uninsured patients who reside in Illinois, Wisconsin, North Carolina, South Carolina, Georgia or Alabama.
- Uninsured patients receiving non-elective, medically necessary outpatient services at an Advocate Health facility or by an Advocate Health participating provider.
- Uninsured patients who fully cooperate through the process of determining and pursuing other coverage options (i.e. Medicaid).
- Uninsured patients who are ineligible for all other coverage options for the account(s) under review.
- Uninsured patients meeting all of the above criteria with a household income between 0% and 300% of the Federal Poverty Guidelines (FPG).

FAS Process

- Eligibility for financial assistance automation is account based.
- The information used to determine eligibility is obtained from a third-party vendor for uninsured outpatient accounts.
- Eligibility is determined based on information from a third-party vendor indicating the likelihood that the patient's income falls within the FPG criteria for 100% financial assistance.
- Accounts may be reviewed for Medicaid or other coverage opportunities prior to extending financial assistance.
- Accounts that qualify through the FAS process will receive 100% financial assistance.
- Patients who are ineligible for financial assistance through the FAS process for hospital services will receive a denial letter with information on how to apply for a financial assistance review.
- Uninsured patients found ineligible for financial assistance through the FAS process can submit a financial assistance application for reconsideration. Eligibility for financial assistance will be contingent on the patient fully cooperating through the process of pursuing Medicaid or other coverage opportunities.

Insured Patients

Financial assistance for insured patients is available once a patient receives a bill. Patients can initiate the process by completing an application via mail or calling Customer Service to request to be reviewed for financial assistance.

Financial Assistance Eligibility Criteria for Insured Patients:

- Insured patients who reside in Illinois, Wisconsin, North Carolina, South Carolina, Georgia or Alabama.
- Insured patients receiving non-elective, medically necessary services at an Advocate Health facility or by an Advocate Health participating provider.
- Insured patients who are in-network[1] based on the patient's third-party insurer benefit plan at an Advocate Health facility or by an Advocate Health provider (or participating provider) with the exception of services received in an Advocate Health emergency department.
- Insured patients with fully adjudicated claims resulting in a self-pay balance.
- Insured patients who fully cooperated with the third-party insurer to resolve payment concerns if applicable. i.e. coordination of benefit questions, accident information etc.
- Insured patients who fully cooperate with the determination of other secondary coverage options.

- Insured patients who are determined to be ineligible for all other secondary coverage options for the account(s) under review.
- Insured patients meeting all the above criteria with a household income between 0% and 300% of the Federal Poverty Guidelines (FPG) will receive 100% financial assistance on the self-pay balance under review.

[1] Under the objectives of the NC Medical Debt Mitigation initiative, insured patients who are residents of North Carolina and receive services at a North Carolina Atrium Health hospital can qualify, regardless of their insurance plan's network status.

Services Ineligible for Financial Assistance

The following services are not eligible for financial assistance:

- Elective and/or cosmetic services
- Non-medically necessary services
- Complementary/Non-Traditional medicine
- Fertility services
- Global & Executive Health services
- Occupational Health services
- Retail services
- Services with packaged pricing
- Services requiring payment upfront in accordance with other hospital or provider policies
- For insured patients, services that are out-of-network based on the patient's third-party benefit plan except for services received in an Advocate Health emergency department
- For insured patients, services not covered by the patient's third-party insurer

Determination of Financial Assistance Eligibility for Uninsured & Insured Patients

- Financial Advocates/Financial Counselors strive to interview uninsured patients to gather information needed to assess the patient's eligibility for coverage options (i.e. Medicaid) as well as information needed to determine financial assistance eligibility. Patients not interviewed can initiate an interview by calling the number provided on correspondence from the Financial Advocate/Financial Counseling team, calling Customer Service or downloading an application and mailing it to the Financial Advocate/Financial Counseling team.
- Insured patients may apply after receiving a bill by calling Customer Service or downloading an application and mailing it to the Financial Advocate/Financial Counseling team.
- In addition to information obtained from the patient, information from third-party sources may be utilized in determining a patient's eligibility for financial assistance, including but not limited to:
  - estimated household income as compared to the FPG)
  - state portals and/or databases providing information on public assistance coverage
  - eligibility tools to search for and verify eligibility for health insurance coverage, Medicaid and public aid coverage
  - Where appropriate, information from third-party sources will be used to validate information provided by the patient in the interview and/or on the financial assistance application. If there is a discrepancy between the information from third-party sources and what the patient provided, the patient may be asked to submit further documentation including but not limited to the following:
  - the patient's most recent year tax returns, W-2s, the patient's income tax documentation, check stubs, unemployment statements, or letters of financial support (if no income). If there is more than one

employed person in the patient's family, each may verify his or her financial information using these same verification options.
    - Proof of state residency can be verified by the patient presenting any two (2) of the following valid forms of identification that indicate the same address: State issued driver's license (or other photo identification card such as a Student or Military ID), utility bills (gas, electric, water) bank statements, car registrations, or any other mail received from a government entity with the current date and address.
    - financial statements and verification of income and third-party vendor documentation will be retained by Advocate Health for a period of 10 years or as required by law. Falsification of financial information, including withholding information, will be reason for denial of financial assistance.
- The patient will be notified of the financial assistance eligibility determination by mail, verbally or in person, as applicable.
- If a patient is determined to be eligible for financial assistance, payments made on eligible services prior to the patient applying for financial assistance will be reviewed to determine if the patient is eligible for a refund.
- Patients determined to be ineligible for financial assistance can call Customer Service to create a payment plan to resolve the patient's remaining self-pay balance. Self-pay balances are subject to Advocate Health Billing and Collections Policy.

Presumptive Eligibility Determinations

A presumptive eligibility determination may be made in accordance with state laws and regulations. Patients who qualify under certain federal and state assistance programs or other non-income based criteria may be considered presumptively eligible for a 100% financial assistance adjustment and no application is necessary. **Information on the process and participating states are listed in Appendix A.**

Eligibility Period

- Uninsured: Financial Assistance will be effective retrospectively for all eligible open self-pay balances, and prospectively for up to 180 days.
    - Future services within the 180 day period may be reviewed for Medicaid or other coverage opportunities. Patients must fully cooperate with the coverage assistance process to maintain financial assistance eligibility for the duration of the 180 day period should they be found ineligible for other coverage.
    - If any changes occur during the eligibility period, the patient is required to cooperate with the coverage assistance process to maintain financial assistance eligibility.
    - The patient shall communicate to Advocate Health any material change in their financial situation that occurs during the 180 day period after approval that may affect their eligibility status. This communication must take place within thirty (30) days of the change. A patient's failure to do so may void any amount of Financial Assistance provided by Advocate Health after the material change occurred.

- Insured: Financial Assistance will be effective for eligible current remaining balances after payment by all third-parties. Patients must re-apply for Financial Assistance for any emergent and medically necessary care occurring in the future.

Fraud

Advocate Health reserves the right to reverse financial assistance adjustments provided by this policy if the information provided by the patient during the information-gathering process is determined to be false or if Advocate Health learns that the patient has received compensation for the medical services from other sources not disclosed to Advocate Health.

Financial Assistance Applications

Financial Assistance applications are for:

- Uninsured patients who were not proactively interviewed by a Financial Advocate/Financial Counselor
- Uninsured patients who were denied financial assistance through the automated Financial Assistance Scoring process and want to be re-considered for financial assistance eligibility
- Insured patients requesting a review for financial assistance after receiving a bill

How to Apply:

- Atrium Health
  - Online using a phone, tablet or computer via the link available on the financial assistance page on the Atrium Health website or going to https://ola.veritysource.com/atrium.
  - Download a financial assistance application by visiting https://atriumhealth.org/for-patients-visitors/financial-assistance and mailing it to:
    Atrium Health Business Office
    ATTN: Coverage Assistance Services
    P.O. Box 32861
    Charlotte, NC 28232-2861
  - Call 704-512-7171 or 1-844-440-6536

- Illinois – Advocate Health Care
  - Download a financial assistance application by visiting http://www.advocatehealth.com/financialassistance and mailing it to:
    Advocate Health Care Financial Advocates
    P.O. Box 3039
    Oak Brook, IL 60522-9908
  - Call 847-795-2300

- Wisconsin – Aurora Health Care
  - Download a financial assistance application by visiting http://www.aurorahealthcare.org/patients-visitors/billing-payment/financial-assistance and mailing it to:
    Aurora Health Care Financial Advocates
    P.O. Box 909996
    Milwaukee, WI 53209-0996
  - Call 1-800-326-2250

Patients have 240 days from the first post-discharge bill date to apply for financial assistance.

Only fully completed applications will be reviewed for financial assistance. An application is considered complete if all fields on the application are complete, any requested documents are received, and a Financial Advocate/Financial Counselor has reviewed the information and deemed the patient ineligible for other coverage opportunities. The application is then processed for financial assistance and a determination is made within a timely manner.

Incomplete Applications: If an application is incomplete or the patient has not provided requested information or taken actions requested by an Advocate Health representative, a Financial Advocate/Financial Counselor will inform the patient and explain what information is needed to complete the application. Information needed

should be provided to Advocate Health within 30 days of the patient being notified unless compelling circumstances are brought to Advocate Health's attention.

Communication of Policy

To make Advocate Health patients and the broader community aware of the availability of Financial Assistance, Advocate Health takes the following measures to communicate the coverage assistance and financial assistance policy and processes:

- Outreach and on-site interviews completed by Financial Advocates/Counselors to assess eligibility for coverage opportunities (i.e. Medicaid) and financial assistance.
- A plain language summary of financial assistance programs is posted in all Emergency departments, patient registration areas and included on all billing statements. The plain language summary includes information on the financial assistance programs available under this financial assistance policy, information on how to apply, the telephone number of the department that can provide information about the financial assistance policy and how to access copies of the financial assistance policy.
- The Advocate Health, Aurora Health Care and Atrium Health websites provide information on available financial assistance programs, how patients can apply, telephone numbers for departments that can provide information on financial assistance, the plain language summary, copies of the financial assistance policy, the financial assistance application and the Billing and Collections policy.
- Inquiries to the Customer Service Department.

Actions in the Event of Non-Payment

Information on Advocate Health's billing and collection practices can be found in a separate billing and collections policy located on the Advocate Health, Aurora Health Care and Atrium Health websites. A free copy of the policy can also be obtained by mail by calling the Customer Service Department at:

- Atrium Health
  - Visit https://atriumhealth.org/for-patients-visitors/financial-assistance
  - Call 704-512-7171 or 1-844-440-6536
- Illinois – Advocate Health Care
  - Visit http://www.advocatehealth.com/financialassistance
  - Call 847-795-2300
- Wisconsin – Aurora Health Care
  - Visit http://www.aurorahealthcare.org/patients-visitors/billing-payment/financial-assistance
  - Call 1-800-326-2250

Quality Assurance and Other Provisions

Quality Assurance: Advocate Health teammates are prohibited from making recommendations and/or processing financial assistance applications for family members, friends, acquaintances, and co-workers. The Patient Financial Services Quality Assurance Department will conduct periodic audits of accounts processed for financial assistance to ensure policy and processes are followed.

Eligibility Criteria Adjustments: Advocate Health may adjust the eligibility criteria in this policy periodically based upon the community health needs assessments or improvement studies conducted for applicable organizations and/or as necessary to comply with applicable laws, regulations, and/or county agreements.

Public Health Emergency Provision: Alternative funding sources due to a public health emergency will NOT prevent uninsured patients from receiving financial assistance for remaining balances that qualify under this policy. As part of Advocate Health's dedication to our community, financial assistance may also be applied to any insured patient copays or responsibility that have been waived but not paid/reimbursed by payors or when conflicting billing guidance is issued during any public health emergency.

Appendix A

In some states, patients enrolled in certain federal and state assistance programs or who meet other non-income based criteria can qualify for 100% financial assistance and no application is necessary.

North Carolina Presumptive Eligibility

- In accordance with the NC Medical Debt Mitigation initiative, presumptive eligibility determinations will be made for patients who are North Carolina residents and receive hospital services at an Atrium Health facility in North Carolina. Patients who qualify under certain federal and state assistance programs or other non-income based criteria will be considered presumptively eligible for a 100% financial assistance adjustment and no application is necessary.
- Presumptive eligibility can be based on patients meeting non-income criteria, including but not limited to:
  - Homelessness
  - Enrollment in means-tested government assistance programs such as Women, Infants and Children Nutritional Program, Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families
  - Medicaid eligibility for the patient or a child in the patient's household
  - Mental incapacitation with no one to act on the patient's behalf
- If at least one criterion for non-income based presumptive eligibility is met, patients are not required to provide documentation or other verification of meeting eligibility.
- The process to determine if patients meet non-income based criteria for presumptive eligibility includes:
  - Information gathered during the check-in/registration process
  - Information may also be obtained from care teams to ensure a comprehensive review is completed
- Patients who meet at least one of the non-income based criteria for presumptive eligibility will qualify for 100% financial assistance and be notified prior to discharge.
- Patients who meet the criteria for presumptive financial assistance eligibility may be reviewed for Medicaid or other coverage opportunities. Those patients will not be held financially responsible if they are later determined ineligible for Medicaid or other coverage opportunities.
- Patients who do not meet criteria for non-income based presumptive eligibility and are not otherwise approved for another financial assistance program as outlined in this policy will receive information on alternative pathways to apply for financial assistance.

Illinois Presumptive Eligibility

- A presumptive eligibility determination may be made for patients in Wisconsin and Illinois in accordance with the IL Fair Patient Billing Act. Uninsured patients who qualify under certain federal and state assistance programs may be considered presumptively eligible for a 100% financial assistance adjustment and no application is necessary.
- If at least one criterion can be verified, no other proof of income will be requested.
- AAH may ask the patient to provide verification of eligibility if the financial advocate is unable to verify eligibility electronically.
- If the financial advocate can determine that a patient is presumptively eligible for Financial Assistance, a written application is not required.
- Presumptive Eligibility Criteria is demonstrated by enrollment in one of the following programs:
  o Women, Infants and Children Nutrition Program (WIC).
  o Supplemental Nutrition Assistance Program (SNAP).
  o Illinois Free Lunch and Breakfast Program.

o Low Income Home Energy Assistance Program (LIHEAP).
o Temporary Assistance for Needy Families (TANF).
o Illinois Housing Development Authority's Rental Housing Support Program.
o Organized community-based program or charitable health program providing medical care that assesses and documents low-income financial status as criteria.
o Medicaid eligibility, but not eligible on date of service or for non-covered service (IL patients only)

- Presumptive Eligibility Criteria can also be demonstrated by the following life circumstances:
  o Receipt of grant assistance for medical services.
  o Homelessness.
  o Deceased with no estate.
  o Mental incapacitation with no one to act on patient's behalf.
  o Incarceration in a penal institution.
  o Affiliation with a religious order and vow of poverty.
  o Evidence from an independent third-party reporting agency indicating family income is less than two times FPL.
- Ways to demonstrate Presumptive Eligibility include:
  o Electronic Confirmation of program enrollment or other presumptive eligibility criteria.
  o Where independent electronic confirmation is not possible, proof of enrollment or other eligibility criteria will be requested. Any one of the following will be satisfactory proof:
  o WIC voucher.
  o SNAP card with proof of enrollment screen print or copy of SNAP approval letter.
  o Letter from the school or Free/Reduced Price Meals & Fee Waiver Notification with signature.
  o LIHEAP award or approval letter.
  o TANF approval letter from Red Cross, DHS, or HFS.
  o Rent receipt in the case of state or federally subsidized housing program.
  o Rent adjustment letter from Lessor or HUD card or letter.
  o Card or Award statement showing current eligibility for State of Illinois program.
  o Statement from Grant Agency or Grant Letter.
  o Personal attestation or letter from church or shelter confirming homelessness.
  o Letter from attorney, group home, shelter, religious order or church