



Prime Healthcare Illinois Medical Group

DEPARTMENTAL POLICIES AND PROCEDURES		Pages:	12
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Subject:	Patient Financial Assistance Policy		
Manual:	Patient Financial Services		

I. Policy:

The Prime Healthcare Illinois Medical Group (the “Medical Group”) offers a financial assistance program for those patients who meet the eligibility tests described in this policy. The Medical Group provides Charity Care and self-pay discounts adhering to the requirements of federal and state law. The intent of this Financial Assistance Policy (the “Policy”) is to satisfy applicable federal and state laws and regulations; all provisions should be interpreted accordingly.

A significant objective of the Medical Group is to provide care for patients in times of need. The Medical Group provides Charity Care and a Discount Payment Program as a benefit to the communities we serve. To this end, the Medical Group is committed to assisting eligible low-income and/or uninsured patients with appropriate Discount Payment and Charity Care Programs. All patients will be treated fairly, with compassion and respect. Notwithstanding anything else in this Policy, no individual who is determined to be eligible for financial assistance will be charged more for emergency or other medically necessary care than the Amounts Generally Billed to individuals who have insurance covering such care. Accompanying this Policy are the following addenda, as referred to throughout this Policy:

- Plain Language Summary of Financial Assistance
- Notice to be included in all post-discharge billing statements
- Notice to be included in post-discharge billing statements to patients who have not provided proof of insurance

For a list of Medical Group locations and contact information, please visit

<https://primeilmedicalgroup.com/>.

II. Definitions:

“Amounts Generally Billed”: The amounts generally billed (“AGB”) for emergency or other medically necessary services to individuals eligible for the Discount Payment Program. The Medical Group calculates the AGB for a patient using the prospective method as defined in the Treasury Regulations. Under the prospective method, AGB is calculated using the billing and coding process the Medical Group would use if the individual were a Medicare fee-for-service beneficiary using the currently applicable Medicare rates provided by the Centers for Medicare & Medicaid Services.



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“Medically Necessary”: “Medically necessary” means any inpatient or outpatient physician service, including pharmaceuticals or supplies provided by a physician to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A “medically necessary” service does not include any of the following:

- i. Non-medical services such as social and vocational services.
- ii. Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.

“Extraordinary Collection Action”: An Extraordinary Collection Action means any collection action involving certain sales of debt to another party, reporting adverse information to credit agencies or bureaus, or deferring or denying, or requiring a payment before providing, medically necessary care because of an individual’s nonpayment of one or more bills for previously provided care covered under the Medical Group’s Financial Assistance Policy, or any action requiring a legal or judicial process, including placing a lien, foreclosing on real property, attaching or seizing of bank accounts or other personal property, commencing a civil action against an individual, taking actions that cause an individual’s arrest, taking actions that cause an individual to be subject to body attachment, and garnishing wages, in each case as further described in [IRS Section 501\(r\)\(6\)](#).

“Family”: (1) for persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for persons under 18 years of age, parent(s), caretaker relative(s), and other children under 21 years of age of the parent(s) or caretaker relative(s).

“Plain Language Summary”: The summary of the Financial Assistance Policy in the “Summary of Financial Assistance” addendum, intended to comply with [IRS Section 501\(r\)\(4\)](#).

III. Applicability of the Policy:

This Policy applies to all emergency and other medically necessary care provided by the Medical Group. This Policy applies only to charges for Medical Group services and is not binding upon other providers of medical services who are not employed or contracted by the Medical Group to provide medical services, including physicians who treat Medical Group patients on an emergency, inpatient or outpatient basis. Physicians not covered by this Policy who provide services to patients who are uninsured or cannot pay their medical bills due to high medical costs may have their own financial assistance policies to provide assistance. The Medical Group is not responsible for the administration of any financial assistance program offered by the non-employed medical staff physicians.



IV. Patient Responsibility

Financial assistance policies must balance a patient's need for financial assistance with the Medical Group's broader fiscal stewardship. Financial assistance through Discount Payment and Charity Care Programs is not a substitute for personal responsibility. It is the patients' responsibility to participate in the financial assistance screening process; reasonably provide the Medical Group with information or documentation permitted under law; apply for coverage under public programs within 30 days of the Medical Group's request, if applicable; and, where applicable, contribute to the cost of their care based upon their ability to pay. Outside debt collection agencies and the Medical Group's internal collection practices will reflect the mission and vision of the Medical Group.

V. Procedure:

1. Eligibility for Financial Assistance

A. Charity Care

A patient qualifies for **Charity Care** if all of the following conditions are met: (1) the patient does not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medicaid, as determined and documented by the Medical Group; (2) the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance, as determined and documented by the Medical Group; and (3) the patient's Family income does not exceed 350% of the Federal Poverty Level.

The patient balances for those patients who qualify for Charity Care shall be reduced to zero dollars (\$0), with the remaining balance eliminated and classified as Charity Care.

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance, as determined and documented by the Medical Group, does not qualify for Charity Care but may qualify for the Discount Payment Program if certain conditions are met, as described in the "Discount Payment Program" section below.

B. Discount Payment Program

Self-Pay Patients

A self-pay patient qualifies for the **Discount Payment Program** if: (i) the patient's Family Income does not exceed 600% of the current Federal Poverty Level; (ii) the patient does not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medicaid; and (iii) the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance, as determined and documented by the Medical Group.



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Insured Patients

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance, as determined and documented by the Medical Group, qualifies for the **Discount Payment Program** if: (i) the patient has a Family Income at or below 600% of the current Federal Poverty Level; and (ii) the patient has out-of-pocket medical expenses that exceed the lesser of: (a) ten percent (10%) of the patient's Family Income in the prior twelve (12) months (whether incurred or paid in or out of any hospital); or (b) the annual out-of-pocket costs incurred by the individual at the Medical Group that exceed 10% of the patient's current Family Income.

Patient Obligation

The patient balances for those patients who qualify for the **Discount Payment Program** will be reduced; any discount will be applied against the gross charges for medical group services provided. The payment obligation of a patient eligible for the **Discount Payment Program** will be determined on a case-by-case basis but will not exceed the greater of (a) the Amounts Generally Billed (AGB); and (b) the amount the Medical Group would expect to receive for providing services from Medicare or Medicaid, whichever is greater (the "Discounted Payment Maximum"). An eligible patient with insurance will be obligated to pay an amount equal to the difference between what the Medical Group receives from the insurance carrier and the Discounted Payment Maximum. If the amount paid by insurance exceeds the Discounted Payment Maximum, the patient will have no further payment obligation.

The **Discount Payment Program** shall also include an interest-free extended payment plan to allow payment of the discounted price over time. The Medical Group and the patient shall negotiate the terms of an extended payment plan, taking into consideration the patient's Family Income and essential living expenses.

C. Medical Group Presumptive Eligibility and Other Circumstances

The Medical Group will comply with all applicable federal and state requirements regarding presumptive eligibility. The Medical Group's Presumptive Eligibility Policy will deem a patient presumptively eligible for financial assistance if they demonstrate one or more of the presumptive eligibility criteria as required by law. The Medical Group may use an outside agency or determination from the Director of the Medical Group's Patient Financial Services ("PFS") Department to extend Charity Care or the Discount Payment Program to patients under the circumstances listed below (presumptive eligibility). Presumptive eligibility does not convey an entitlement for future services. The Medical Group also may not disclose presumptive eligibility determination and may not have access to the data utilized by an outside agency. The circumstances below are considered forms of Charity Care and may be documented as reflected in the transaction code used to adjudicate the patient's claim, including but not limited to transactions related to Charity Care, self-pay discounts, non-covered services and denials.

(i) The patient qualifies for limited benefits under the state's Medicaid program, *i.e.*, limited pregnancy or emergency benefits, but does not have benefits for other services provided at the Medical Group. This includes non-covered services related to:



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- Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients who only have pregnancy or emergency benefits but receive other care from the Medical Group);
- Medicaid pending applications that are not subsequently approved, provided that the application indicates that the patient meets the criteria for Charity Care;
- Medicaid or other indigent care program denials;
- Charges related to days exceeding a length of stay limit; and
- Any other remaining liability for insurance payments.

(ii) The patient qualifies for a county-level medically indigent services program, but no payment is received by the Medical Group.

(iii) Reasonable efforts have been made to locate and contact the patient, such efforts have been unsuccessful, and the Medical Group's PFS Director has reason to believe that the patient would qualify for Charity Care or the Discount Payment Program, e.g., patient is deceased, bankrupt, incarcerated (and not reimbursed by a State Medicaid program), non-responsive, homeless, or unwilling to provide documentation.

(iv) A third-party collection agency has made efforts to collect the outstanding balance and has recommended to the Medical Group's PFS Director that Charity Care or the Discount Payment Program be offered.

(v) Subsequent to collection efforts and payor negotiations, any unreimbursed charges from non-cosmetic services, including non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials, are considered a form of patient financial assistance. Charges related to these discounts written off during the fiscal year are reported as uncompensated care.

(vi) The patient is eligible for programs including, but not limited to:

- State-funded prescription programs;
- Women, Infants and Children programs (WIC);
- Supplemental Nutrition Assistance Programs (SNAP), i.e., food stamps;
- Subsidized school lunch programs;
- Other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
- Low income/subsidized housing is provided as a valid address; and
- Historical significance of non-payment that establishes a justification of future non-payment and lack of ability to pay.

(vii) Other circumstances of Charity Care shall be documented in the patient's record indicated either by transaction type or in the patient's notes.



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D. Determination of Income

For purposes of determining eligibility for the Charity Care and Discount Payment Programs, documentation of income of the patient's Family shall include any one of the following: copies of the two most recent pay stubs, a copy of the most recent tax return; a copy of the most recent W-2 form and 1099 forms, written income verification from an employer if paid in cash; or one other reasonable form of third-party income verification deemed acceptable to the Medical Group. The financial assistance application requests patient information necessary for determining patient eligibility under this Policy, including patient or Family Income and patient's family size. The Medical Group will not request any additional information other than the information requested in the financial assistance application. A patient seeking financial assistance, however, may voluntarily provide additional information if they choose. Qualification for financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

E. Federal Poverty Levels

The measure of the Federal Poverty Level shall be made by reference to the most up to date Health and Human Services Poverty Guidelines for the number of persons in the patient's Family or household. HHS Poverty Guidelines 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 and are available at <https://aspe.hhs.gov/poverty-guidelines> or per request from the Medical Group's Patient Financial Services Department at 773-589-4407.

2. Application Process

Any patient who requests financial assistance or who is identified as eligible for financial assistance by the Medical Group's screening process will be asked to complete a financial assistance application. The application includes the office address and phone number to call if the patient has any questions concerning the financial assistance program or application process. A patient is expected to submit the financial assistance application promptly following care, but no later than two hundred forty (240) days following the date of the first post-discharge statement.

To request a financial assistance application, please contact us:

773-589-4407
Prime Healthcare Illinois Medical Group
Attn: Patient Financial Services
P.O. Box 74008843
Chicago, IL 60674-8843

3. Resolution of Disputes

Any disputes regarding a patient's eligibility for financial assistance shall be directed to and resolved by the Medical Group's Chief Financial Officer.



4. Publication of Policy

In order to ensure that patients are aware of the existence of this Policy, the Medical Group shall take the following measures:

- Notice of the availability of financial assistance shall be clearly and conspicuously posted in locations that are visible to the patients in the Medical Group's offices and prominently displayed on the Medical Group's internet website, with a link to the Policy itself.
- Every patient who is seen at the Medical Group shall receive the notice in the "Plain Language Summary of Financial Assistance" addendum. The notice shall be provided at the time of service. The notice shall be provided in English and non-English languages spoken by a substantial number of the patients served by the Medical Group.
- Each bill that is sent to a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge must include the "Notice to be included in post-discharge billing statements to patients who have not provided proof of insurance" included in the addenda. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Medical Group.

5. Efforts to Obtain Information

The Medical Group shall make all reasonable efforts to screen all patients, upon the patient's agreement, for Medical Group financial assistance and public health insurance program eligibility at the earliest reasonable moment. The Medical Group will review and assess the patient's potential eligibility for financial assistance offered by the Medical Group, private health insurance, the federal health insurance marketplace, Medicare, Medicaid, and/or other government-funded programs, or other discounted care known to the Medical Group. The screening will assess private or public health insurance that may fully or partially cover the charges for care rendered by the Medical Group to the patient. The Medical Group will inform the patient of the Medical Group's assessment, will document in the patient's record the circumstances of the screening, and will assist with the application for financial assistance. The Medical Group shall offer to screen an insured patient for Medical Group financial assistance under this Section if the patient requests financial assistance screening, if the Medical Group is contacted in response to a bill, if the Medical Group learns information that suggests an inability to pay, or if the Medical Group becomes aware of other circumstances that suggest the patient's inability to pay.

If a patient does not indicate that he/she has coverage by a third party payor or requests financial assistance, Medical Group staff shall provide the patient with a notice that includes the following: (a) a request that the patient inform the Medical Group if the patient has private or public health insurance coverage or other coverage; (b) a statement that, if the patient does not have health insurance coverage, the patient may be eligible for coverage under the state's Medicaid program or other governmental programs; (c) a statement indicating how the patient may obtain applications for the state's Medicaid program or other governmental programs (and, as appropriate, the Medical Group will provide such applications to the patient); and (d) information regarding the Medical Group's financial assistance program.



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If a patient declines or fails to respond to the Medical Group's screening or follow up regarding the application submission, the Medical Group will document in the patient's record the patient's decision to decline or failure to respond.

6. Collection Activities

The Medical Group may use the services of one or more external collection agencies for the collection of patient debt. Prior to engaging in collection activities, the Medical Group will provide uninsured patients with an accurate bill, the opportunity to apply for financial assistance under the Medical Group's financial assistance policy and the opportunity to apply for a reasonable payment plan. No debt shall be advanced for collection until the Medical Group's Patient Financial Services Director, or his/her designee has reviewed the account and approved the advancement of the debt to collection. If a financial assistance application is received and is incomplete, the Medical Group will provide written notice of the outstanding items and wait a reasonable period of time before initiating or resuming Extraordinary Collection Actions. No Extraordinary Collection Actions will be commenced by the Medical Group until after at least 90 days following the date of discharge, receipt of outpatient services, or initial bill (whichever comes latest).

Any collection agency utilized by the Medical Group shall comply with any payment plan entered into between the Medical Group and the patient. If a patient applies for financial assistance, any collections actions will be suspended pending the decision on the patient's financial assistance application. If, during collections, it is discovered the patient qualifies in whole, or in part, for Charity Care or a self-pay discount, collection efforts will cease, and the respective balance will be written off to Charity Care or as a self-pay discount. Neither the Medical Group nor any collection agency utilized by the Medical Group shall (i) use wage garnishments or liens on primary residences to collect unpaid medical bills or (ii) report adverse information to a consumer credit reporting agency or commence civil action against a patient for nonpayment at any time prior to 150 days after the initial billing. The Medical Group will not pursue legal action for non-payment of a medical bill against uninsured patients who have clearly demonstrated that they do not have sufficient income or assets to meet their financial obligations.

At least thirty (30) days before commencing any Extraordinary Collection Actions, the Medical Group must send a notice to the patient which specifies the following: (i) collection activities the Medical Group or contracted collection agency may take; (ii) the date after which such actions may be taken, (iii) that financial assistance is available for eligible patients; (iv) the dates of service of the bill that are being assigned to collections; (v) the name of the entity the bill is being assigned or sold to; (vi) information on how the patient can obtain an itemized bill from the Medical Group; (vii) the name and plan type of the health coverage for the patient on record with the Medical Group at the time of services, or a statement that the Medical Group does not have that information; (viii) an application for the Medical Group's Charity Care and other financial assistance programs; and (ix) the date the patient was originally sent a notice of financial assistance availability, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision was made.



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If a complete application is received within the two hundred forty (240) day application period, any Extraordinary Collection Actions will be suspended while a determination of eligibility is made.



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Financial Assistance & Charity Care Program – Plain Language Summary

The Prime Healthcare Illinois Medical Group is committed to caring for the entire community. To support individuals who may not have health insurance or the financial means to pay for medical care, we offer a comprehensive **Financial Assistance & Charity Care Program**. This program reflects our commitment to providing compassionate, high-quality healthcare to all who qualify.

Financial assistance documents, including the policy, this plain language summary and application, are available in multiple languages and can be found on our website at:

<https://primeilmedicalgroup.com/home/financial-assistance/>.

Who Qualifies for Assistance?

- **Charity Care/Full Coverage (100% Discount):**
Available to individuals or families with income at or below 350% of the Federal Poverty Level (FPL). Eligible patients may receive a 100% write-off of the portion of charges they are responsible for.
- **Financial Assistance/Partial Coverage (Discounted Rates):**
May be available to those with income below 600% of the FPL. Eligible patients may receive discounted rates for emergency and medically necessary care.

How to Apply:

To be considered for financial assistance, patients must:

- Complete a Financial Assistance application and submit all required documentation as outlined on the form.
- Cooperate in good faith throughout the screening and application process, including responding promptly to any information requests from Medical Group staff.
- Provide all requested financial and supporting documentation within 30 days of the Medical Group's request.

Important Information:

- **Other Payment Sources**
Before financial assistance can be considered, all other payment options must be used, including insurance, third-party payers, liability claims, workers' compensation, or other public programs.
- **Limited Provider Participation**
Not all services or providers are covered under the Medical Group's Financial Assistance & Charity Care Program. Services provided by healthcare professionals who are not employed or contracted by the Medical Group may not qualify.

Need Help or Have Questions?

Our patient representatives are available to assist with the application process and to answer any questions you may have, call **773-589-4407**.

Ready to Apply?

Mail the application and supporting documentation to:

Prime Healthcare Illinois Medical Group
Attn: Patient Financial Services
P.O. Box 74008843
Chicago, IL 60674-8843



Prime Healthcare
Illinois Medical Group

[Notice to be included in all post-discharge billing statements]

Charity Care & Discount Payment Program

Patients who lack insurance or who have inadequate insurance and meet certain low-and moderate-income requirements may qualify for discounted payments or Charity Care. Patients seeking discounted or free care must obtain and submit an application that will be reviewed by the Prime Healthcare Illinois Medical Group. No patient eligible for financial assistance will be charged more for emergency or medically necessary care than amounts generally billed to individuals who have insurance covering such care. For more information, copies of documentation, or assistance with the application process, please contact the Medical Group at 773-589-4407 or visit <https://primeilmedicalgroup.com/home/financial-assistance/> to obtain further information. Free copies of financial assistance documentation may also be sent to you by mail and are available in non-English languages spoken by a substantial number of the patients served by the Medical Group. Physicians who are not employees or contractors of the Medical Group may also provide Charity Care or Discount Payment Programs. Please contact 773-589-4407 for further information.



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Notice to be included in post-discharge billing statements to patients who have not provided proof of insurance

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medicaid, state-funded health coverage programs, or other similar programs. If you do have such coverage, please contact our office at 773-589-4407 as soon as possible so the information can be obtained and the appropriate entity billed.

If you do not have health insurance coverage, you may be eligible for Medicare, Medicaid, coverage offered through the federal health insurance marketplace, state- or county-funded health coverage, or the Prime Healthcare Illinois Medical Group's Charity Care or Discount Payment Program. For more information about how to apply for these programs, please contact our office so we can answer your questions and provide you with applications for these programs.