



Information on Employment Assistance, Health Insurance, and Financial Assistance Programs



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Family and Medical Leave Act (FMLA)

Q: What is FMLA?

A: FMLA provides Employees with up to 12 weeks of unpaid, job protected leave per year.

Q: Am I eligible for FMLA?

A: It is important to speak with your employer or HR department for specifics to your employer. Generally, families must meet these requirements to qualify for FMLA:

- Worked for employer for 12 months or more
- Birth, adoption or foster care of an infant or child within one year of birth or placement
- Care of spouse, son or daughter with a serious health condition
- A serious health condition that makes employee unable to perform the essential of his or her job

Q: Can I be terminated while on FMLA?

A: When you use FMLA you are entitled to return to work with the same position with the same capacity as they had prior to their leave and cannot be terminated provided you follow the prearranged FMLA plan.

Q: What are the different types of FMLA and how do I pick the right one for me?

A: There are three types of FMLA, picking the right one for you and your family is dependent on the care required for your child.

- Continuous leave under FMLA means the employee can take the 12 weeks of leave all at once. This is common when families experience the birth or adoption of an infant.
- Intermittent leave under FMLA means the employees can take 12 weeks of leave more irregularly. This is beneficial for employees that may not be able to predict when they will need to go on leave from work. For example, families with changing hospital admission schedules.
- Reduced schedule leave under FMLA means the employee needs to work fewer hours than the standard work week due to their own serious health condition or that of a spouse, son, daughter, or parent. This typically looks like shortened daily work hours.

Steps to Receiving FMLA

1. Speak to your employer or HR department to see if your company offers FMLA and if you qualify.
2. Select which type of FMLA would be appropriate for you and your family.
3. Ask your HR department or employer for their FMLA paperwork.

- Your employer can fax the paperwork to the appropriate medical personnel, or you can give it to the appropriate person
4. The appropriate medical personnel will fill out the FMLA paperwork and return it to you or your employer.
 5. Once paperwork has been sent to employer reach out to your employer to confirm FMLA status.

Who fills out my FMLA Paperwork?

Q: Should my PCP, hospitalist, or medical specialist fill out my FMLA paperwork?

A: You/your child's **PCP** (Primary Care Physician) should fill out the medical portion of your FMLA paperwork if you will be following up with them primarily. Have you/your child's **hospitalist** complete the medical portion if this is a single hospitalization that does not involve your PCP or a medical specialist (examples for hospitalist: PICU, general pediatrics admissions) Lastly, have you/your child's **medical specialist** fill out your FMLA paperwork if you will be following up with them regularly in the future (examples for medical specialist: pediatric oncology, rheumatology).

Additional Information

Employers may offer additional assistance for leave/time off due to medical or family circumstances.

Some employers offer a program that allows colleagues to donate sick time/sick days to you if additional time off is needed.

Make sure to ask your employer about your benefits!

Health Insurance 101

Q: What is health insurance?

A: Health insurance is product that covers your medical expenses. Like auto insurance covers your expenses if you get in an accident, health insurance covers your expenses if you were to get sick or injured. Health insurance may also cover preventative care – i.e. doctors' visits and tests before you get sick. Health insurance does not always cover 100% of your medical expenses. It is designed to *share* costs with you until a certain point, the out-of-pocket limit. Once this out-of-pocket limit has been hit insurance will cover 100% of costs.

Q: Does my child or I need Health Insurance?

A: Yes, it is important to have health insurance as many medical costs are simply too high to cover out of pocket.

****All children under the age of 18 can receive health insurance no matter their status.**

Q: What does premium mean?

A: It's easy to think of your premium as your monthly bill. Every month, you pay a premium to a health insurance company in order to access a health insurance plan. How much you pay monthly is not equivalent to how much you pay on health care services. Typically, plans with lower premiums will likely mean you will have to pay more out of pocket if you were to become sick or injured.

Q: What does deductible mean?

A: A deductible is how much you need to pay for health care services out-of-pocket before your health insurance kicks in. In most plans, once you pay your deductible, you'll still need to pay copays and coinsurance until you hit the out-of-pocket max, after which the plan pays for 100% of services. Typically, plans with lower premiums tend to have higher deductibles.

Q: What does copayment mean?

A: Often shortened to just "copay", it is a fixed amount that you pay for a specific service or prescription medication. Copayments are one way that health insurers will split costs with you after you hit your deductible. You may also have copayments on specific services before you hit your deductible.

Q: What does coinsurance mean?

A: Coinsurance is another way health insurers will split costs with you. Coinsurance isn't a fixed cost – but a percentage of the cost that you pay for covered services. For example, if you have a coinsurance of 15%, you'll pay 15% of the cost of covered services until you reach your out-of-pocket maximum.

Q: What does out-of-pocket maximum mean?

A: Also called out of pocket limit. This term means this is the most you'd ever have to pay for covered health care services in a year.

Q: What health services are covered by your plan?

A: If you are having specific questions as to whether a service will be covered it is best to speak with your health insurance provider.

You can also reach out to a UChicago Financial Assistance specialist at OPSFInacialAssitance@uchospitals.edu

Q: What is the difference between in-network and out-of-network?

A: In-Network means your insurance provider works with that particular hospital/clinic - I.e. if you are in-network at UChicago Hospitals and Clinics you will have some type of coverage. If you are out-of-network your insurance provider does not work with that particular hospital and you will either have to pay more towards deductible/copay/co-insurance/out of pocket maximum OR not have coverage at all if you decide to follow at that hospital. In order to determine what coverage you would have at an out of network hospital/clinic, please speak with your specific insurance company representative.

Two Types of Health Insurance

Generally, there are two types of health insurance: Public health insurance and private health insurance.

Public health insurance is paid for entirely by public/government funds (i.e. Medicare, Medicaid). Private health insurance is paid for in part by the individuals being covered (i.e. employer sponsored insurance plans, Marketplace plans, etc.). Several different public options are available dependent on your state but have strict eligibility requirements. Private health insurance can be offered through an employer or purchased by individuals.

Types of Private Insurance

1) HMO: Health Maintenance Organization

HMO plans are the most restrictive private health insurance plan when it comes to accessing your network providers. If you have an HMO plan, you'll be asked to choose a primary care physician (PCP) that is in-network. All your care will be coordinated by your PCP, and you'll need a referral from your PCP to see a specialist or have certain procedures done. HMO's do not cover any out-of-network health care costs that have not been pre-approved or referred to.

HMO plans typically have cheaper premiums than other types of private health insurance plans.

2) PPO: Preferred Provider Organization

PPO plans are the least restrictive type of plan when it comes to accessing your network of providers and getting care from outside the plan's network. Typically, you have the option between choosing between an in-network doctor, who you can see at a lower cost, or an out-of-network doctor at a higher cost. You do not need a referral to see a specialist; though it is encouraged to have a PCP (some states require that you have a PCP)

PPO plans typically have more expensive premiums than other types of private health insurance plans.

3) EPO: Exclusive Provider Organization

EPO plans are a mix between HMO plans and PPO plans. EPO plans give you the option of seeing a specialist without a referral. However, EPO plans do not cover out-of-network physicians.

4) POS: Point of Service

POS plans are another hybrid of HMO and PPO plans. You'll have a PCP on an HMO-style network that can coordinate your care. You'll also have access to a PPO-style network with out-of-network options (albeit at a higher cost). The HMO network will be more affordable, and you will need to get a referral to see HMO specialists.

Public Insurance Offered in Illinois

Medicaid

Medicaid is a federal and state health insurance program for low-income families and individuals. Medicaid has eligibility requirements that are set on a state-by-state basis, but it is primarily designed for those with low incomes and low liquid assets. It is also designed to help families and caretakers of small children in need.

Medicaid is a jointly funded state and federal government program that pays for medical assistance services. Medicaid pays for medical assistance for eligible children, parents and caretakers of children, pregnant women, persons who are disabled, blind or 65 years of age or older, low income adults aged 19-64, and those who were formerly in foster care services.

Primary services funded through Medicaid are physician, hospital and long-term care. Additional coverage includes drugs, medical equipment and transportation, family planning, laboratory tests, x-rays and other medical services.

Who is eligible for Illinois Medicaid?

To be eligible for Illinois Medicaid, you must be a resident of the state of Illinois, a U.S. national, citizen, permanent resident, or legal alien, in need of health care/insurance assistance, whose financial situation would be characterized as low income or very low income. You must also be one of the following:

- Pregnant, or
- Be responsible for a child 18 years of age or younger, or
- Blind, or
- Have a disability or a family member in your household with a disability
- Be 65 years of age or older
- Be aged 19-64 and meet financial criteria for eligibility

- You can also qualify based on the number of people in your household and your annual household income.

How do I apply for Illinois Medicaid?

You can call 1-800-843-6154 or go to enrollhfs.illinois.gov

I have private insurance but want to see if I can have Medicaid as secondary insurance.

This is very common; you can call 1-800-843-6154 for assistance and to see if you qualify. You can also go to enrollhfs.illinois.gov to see which plan is best for you.

My Medicaid is Out-of-Network with the Hospital/Clinic – How do I switch?

To switch your Medicaid plan, you can go to enrollhfs.illinois.gov or call 877-912-8880. They will let you know when you are eligible to switch to any in-network insurance.

Health Insurance Information Specific to Comer Children's Hospital

The list of In-Network Insurance Plans is always changing.

You can go to: <https://www.uchicagomedicine.org/comer/patients-and-visitors/patient-information/insurance> to see which plans UChicago Comer Children's is currently in-network with.

What if I don't see my insurance listed?

The list of accepted insurance providers is subject to change at any time. You should contact your insurance company to confirm UChicago Medicine participates in their network before scheduling your appointment. Your insurance plan's customer service representatives can also help you verify your benefits, out-of-pocket costs and coverage. If your insurance company is not listed in the link above, or if you have any other questions, please contact Managed.Care@uchospitals.edu.

Additional Financial Assistance Opportunities

Cash, SNAP (Food Stamps), & Medical Assistance

How to apply?

You can apply and manage your benefits online at: <https://abe.illinois.gov/abe/access/>

You can also apply with paper documents at your local DHS office.

STEPS:

- 1) Download the application from: <https://www.dhs.state.il.us/page.aspx?item=33698>
- 2) Follow the directions on the form. Type in as much information as you can. If you can't answer all the questions, that's ok. You must include your name and address. You may print out the application and write on it if you prefer. You must sign the form.
- 3) Once you've completed the application, carry, mail or fax it to your local Family Community Resource Center.

****You can find your local office at:** <https://www.dhs.state.il.us/page.aspx?module=12>

What's next after you apply?

The application process begins the day your DHS office receives your signed application (or electronically signed application). You will be asked to come to the office for an interview or participate by phone if you are unable to come to the office.

You will be asked for various types of documents such as:

- proof of your identity
- proof of your residence
- proof of Social Security numbers for all people on your application
- other types of documents depending on your circumstances.

The DHS caseworker will tell you what you need to bring.

****These assistance programs will need re-certification (also called re-determination) every year in order to remain active.**

Need Additional Assistance with Applying or Managing your Benefits?

You can call 1-800-843-6154 to assistance.

Changes to Address, Income, or Assests

To report changes in income or assests:

1) Cash Assistance & Medical Assistance

- Change Report Line is 1-800-720-4166
- Accepting changes from 8:00 am - 5:30 pm
Monday through Friday, except state holidays.

2) SNAP (formally known as Food Stamps)

- Fill out this benefits reports form:
<https://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL444-1978-IES.pdf>
- Then mail It to your Family Community Resource Center. You can locate that at this website: <https://www.dhs.state.il.us/page.aspx?module=12&officetype=5&county=>

Supplemental Security Income (SSI) Benefits

SSI provides monthly cash payments to help meet the basic needs of low income children and adults who have a physical or mental disability or who are blind. If you are an adult or care for a child or teenager with a disability, and have limited income and savings or other resources, you/your child may be eligible for SSI.

How Do I Apply for SSI for my Child?

- 1) Call our toll-free number, 1-800-772-1213. Explain that you want to file an SSI application on behalf of a child.
- 2) Or go to your local Social Security Office and ask to file an SSI application on behalf of the child. You can find your local Social Security Office at: <https://www.ssa.gov/locator/>
- 3) Or you can start the process online at: <https://secure.ssa.gov/apps6z/i3820/main.html>

How Do I Apply for SSI for myself?

- 1) 1) Start the application process by going to www.socialsecurity.gov/applyforbenefits and begin an application. You can also start the application process by calling 1-800-772-1213.
- 2) Or go to your local Social Security Office and ask to file an SSI application. You can find your local Social Security Office at: <https://www.ssa.gov/locator/>

What's Next?

You will have a case manager if you are accepted based on your eligibility. This case manager will be the best point of contact to manage your case and answer any questions.

Women, Infants, and Children (WIC)

Who is eligible for WIC?

Women and their children who are:

- Pregnant, breastfeeding or just had a baby
- Infants and Children under 5 years old (including foster children)
- Families with a low to medium income
- Use the Pre-Screening Tool: <https://wic.fns.usda.gov/wps/pages/preScreenTool.xhtml> to find out if you might qualify for WIC benefits

What can WIC provide?

- Debit card to buy healthy foods - like milk, juice, eggs, cheese, cereal, dry beans or peas, and peanut butter
- Information about nutrition and health to help you and your family eat well and be healthy
- Information and help about breastfeeding
- Help in finding health care and other services in your area

How to apply:

- 1) Go to: <https://www.dhs.state.il.us/page.aspx?module=12&officetype=11&county=> to find your local Women, Infants and Children office near you. Make an appointment and find out what papers or documents you need to bring with you. At your appointment, WIC staff will check to see if you and your family qualify.
- 2) You will need a WIC referral form from your child's PCP indicating the type of nutrition your child needs.

If you need assistance, contact the state WIC Office at (217) 782-2166.

UCHICAGO FINANCIAL ASSISTANCE APPLICATION

- 1) You can apply for financial assistance for the UChicago Medicine/UChicago Physicians group bills via MyChart
- 2) You can complete a paper copy of the application (found here: <https://www.uchicagomedicine.org/patients-visitors/patient-information/billing/financial-assistance> under *How to Apply for Financial Assistance*) and submit application and supporting documents to billingcustomercare@uchospitals.edu
 - a. Your social worker can assist with submitting this application as well.