

Subject:	Originally <u>Issued</u>	Date of This <u>Revision</u>	<u>Page</u>	<u>No.</u>
ILLINOIS UNINSURED/INSURED/SELF PAY DISCOUNT POLICY	2/01/08	12/08/14	1 of 16	

POLICY STATEMENT:

As a condition of participation in the Medicaid disproportionate share program (if applicable) and to comply with Illinois Public Act 95-0965, and to serve the health care needs of our community, Crossroads Community Hospital will provide Discounted Care to uninsured patients, who do not otherwise qualify for third party coverage, local, state and/or governmental assistance with their health care bills.

Discounted Care will be provided to all uninsured patients without regard to race, ethnicity, sex, sexual orientation, creed, color, religious beliefs or national origin.

Patients may apply for the discount within 60 days of the discharge date from the receipt of the service.

All Illinois Hospitals will charge Illinois residents no more than 135% of charges based on their most recently filed Medicare cost report.

PURPOSE:

To properly identify those patients who do not have insurance and do not qualify for third party coverage, state and/or government assistance or Free Care per the Hospital's Charity Care Policy and to provide assistance with their medical expenses under the guidelines set forth herein.

All capitalized terms are defined in Appendix A hereto.

ELIGIBILITY FOR DISCOUNTED CARE

1. To be eligible for a reduction in a balance due the patient must be uninsured and the Hospital services not covered in whole or part, by any other third party source.
2. The Family Income must be 300% of the Federal Poverty Income guidelines, or less at Critical Access or Rural Area Hospitals or 600% of the Federal Poverty Income or less at Urban Area Hospitals. A hospital, other than a rural hospital or Critical Access Hospital, shall provide a charitable discount of 100% of its charges for all medically necessary health care services exceeding \$300 in any one inpatient admission or outpatient encounter to any uninsured patient who applies for a discount and has family income of not more than 200% of the federal poverty income guidelines. A rural hospital or Critical Access Hospital shall provide a charitable discount of 100% of its charges for all medically necessary health care services exceeding \$300 in any one inpatient admission

or outpatient encounter to any uninsured patient who applies for a discount and has family income of not more than 125% of the federal poverty income guidelines.

3. Patients who do not provide the documents required to make a determination for discounted care may either be denied a discount or may only be eligible for the minimum discount of 35%. Patients shall have 60 days from the date of discharge to apply for Discounted Care.
4. The services the patient receives must be Medically Necessary services.
5. For all health care services exceeding \$300 in any one inpatient admission or outpatient encounter, a hospital shall not collect from an uninsured patient, deemed eligible under subsection (a), more than its charges less the amount of the uninsured discount.
6. A patient applying for Discounted Care must be an Illinois Resident and provide acceptable Family Income verification. Acceptable forms of verification of Illinois residency includes one of the following in current form:
 - Any document listed on acceptable family income verification
 - A valid state issued identification card
 - A recent residential utility bill
 - A lease agreement
 - A vehicle registration card
 - A voter registration card
 - Mail addressed to the uninsured patient at an Illinois address from a government or other credible source
 - A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
 - A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

THE AMOUNT OF THE DISCOUNT PROVIDED

PATIENTS WHO DO NOT PROVIDE PROOF OF INCOME OR RESIDENCY ; WHO ARE NOT ELIGIBLE FOR SELF PAY DISCOUNT OR WHOSE CHARGE FOR AN INPATIENT OR OUTPATIENT ENCOUNTER IS LESS THAN \$300: these patients are eligible for a minimum discount of 35% off billed charges.

PATIENTS WHO PROVIDE PROOF OF ILLINOIS RESIDENCY, WHO ARE ELIGIBLE FOR A SELF PAY DISCOUNT AND WHOSE CHARGES FOR AN INPATIENT OR OUTPATIENT ENCOUNTER IS MORE THAN \$300: a discount will be provided based on 135% of the Hospital cost based on the most recently filed Medicare Cost Report. Therefore, the amount of the discount is subject to change each year.

However, the maximum amount that may be collected in a 12-month period from eligible patients is 25% of the patient's Family Income, excluding patients with substantial assets as described in Appendix B. The 12 month period to which the maximum amount applies shall

begin on the first date an uninsured patient receives health care services that are determined to be eligible for the uninsured discount at that hospital.

- A 12 month period begins as of the first date of service determined to be eligible for a discount.
- The patient must inform the Hospital that he/she has received prior services from the Hospital which were eligible for the discount
- Substantial assets do not include primary residence, personal property and amounts held in a pension or retirement plan

EXCLUDED UNDER THIS POLICY

1. Patient's covered by any insurance, local, state or government health care coverage or other third party coverage. This includes any portion of a Hospital bill where the patient's insurance has denied or excluded certain services from coverage.
2. Patients who qualify and receive Free Care under the Hospital's Charity Care Policy.
3. Charges for services that are not Medically Necessary.
4. Any other patient/account already receiving a discount; such as (but not limited to) Industrial Accounts or Client Accounts.
5. Hospital based physician charges.

THE PROCESS

1. **Identification of Patients Eligible for Discounted Care:**
 - A. The Hospital will include a statement on each Hospital bill or summary of charges of the availability of Financial Assistance for those who are uninsured or may otherwise need assistance with a bill for services and how to contact the Hospital for information for same. The statement will include information regarding income requirements. In addition, the Hospital's policy on Financial Assistance/Discounted Care and its application for same shall be posted on the Hospital's website. The application shall be in English and any other language that is common to 5% or more of the Hospital's patients.
 - B. All patients with no insurance who do not qualify for Charity Care or who do not apply for Charity Care will be eligible for a discount off billed charges (subject to charges exceeding \$300 of charges in any one Inpatient and Outpatient encounters)., excluding encounters where charges are \$300 or less. No discount will be provided when the total charge for that encounter is \$300 or less.
 - C. During the screening process, the financial counselor or self pay screening vendor will screen for potential Medicaid eligibility as well as coverage by other sources,

including governmental programs. During this screening process a Financial Assistance ("FA") application will be completed. (Appendix B) Patients will be required to cooperate and apply for Medicare, Medicaid, AllKids, SCHIP, or any other public program providing there is reason to believe they would qualify. Proof of denial will be required for the patient to be eligible for the discount above the minimum uninsured discount.

- D. All uninsured patients will be screened for existing Medicaid coverage by using the Hospital's insurance eligibility software. A copy of the response will be retained as verification that the patient did not have Medicaid coverage.
- E. The Hospital will view prior accounts for the patient as well as the guarantor to determine if insurance coverage existed in the 12 months prior to the date services are rendered. If so, the Hospital will 'attempt to verify insurance coverage' and document the call and response.
- F. When it is determined the patient does not qualify for Medicare, Medicaid or any other third party coverage and the patient does not qualify for Free Care under the Hospital's Charity Care Policy, an uninsured patient the patient will be presumptively eligible for Discounted Care, but must nonetheless complete the Hospital's FA to confirm same.
- G. Patients who are not screened for Medicare, Medicaid and other third party coverage, due to the patient not returning calls or providing the necessary information to make a determination of coverage and who do not provide the necessary information to determine eligibility for Discounted Care will only be eligible for the minimum uninsured discount off billed charges.
- H. Proof of Income and/or residency must be provided within 30 days of request.

Acceptable forms of documentation of Family Income shall include one of the following:

- A copy of the most recent tax return
- A copy of the most recent W-2 and 1099 forms
- Copies of the 2 most recent pay stubs
- Written income verification from an employer, if paid in cash
- One other reasonable form of third party income verification deemed acceptable to the Hospital

Acceptable forms of documentation of residency shall include one of the following:

- Any document listed on acceptable family income verification
- A valid state issued identification card
- A recent residential utility bill
- A lease agreement
- A vehicle registration card
- A voter registration card

- Mail addressed to the uninsured patient at an Illinois address from a government or other credible source
- A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
- A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

2. FAILURE TO PROVIDE ACCURATE INFORMATION

If it is later determined that the patient qualified for coverage by Medicare, Medicaid or any other third party coverage any discount provided for under this policy shall be reversed.

If any information provided by the patient/guarantor is later found to be untrue, any discount provided may be forfeited.

3. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

- A. For those patients screened by the Hospital financial counselor or self-pay screening vendor, once the eligibility determination has been made, the results will be documented in the comments section on the patient's account.
- B. The discount will be set in the system and will not require Hospital authorization.
- C. The transaction code used will reflect 'Self Pay Discount' and will not be considered Charity.
- D. The 35% discount applied to all self-pay accounts will be adjusted with transaction codes 556 for Inpatient, and 557 for Outpatient.
- E. If the patient qualifies for the Illinois Uninsured Patient Discount; the 35% discount shall be reversed and a new discount will be applied using the following codes:

Inpatient Discount — Transaction code 558

Outpatient Discount Transaction code 559

Bad Debt Inpatient Discount — Transaction Code 794

Bad Debt Outpatient Discount — Transaction Code 795


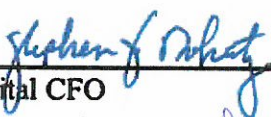
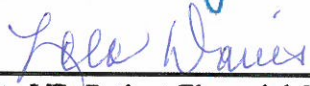
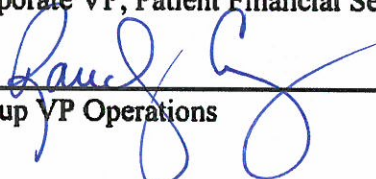
4. REPORTING OF DISCOUNTED CARE

Information regarding the amount of Discounted Care provided by the Hospital, based on the Hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require). In addition, the Hospital will provide the Attorney General's office an annual report regarding all applications for Financial Assistance, those denied and those accepted.

Illinois Hospitals must annually file a copy of Worksheet C Part I of their Medicare Cost Report with the Attorney General's office. The first filing is due 2/20/09.

5. **POLICY REVIEW AND APPROVAL**

The below individuals have read and approved this policy:

 _____ Hospital CEO	<u>12/8/2014</u> Date
 _____ Hospital CFO	<u>12-08-14</u> Date
 _____ Corporate VP, Patient Financial Services	<u>12/9/14</u> Date
 _____ Group VP Operations	<u>12/10/14</u> Date

Appendix A Definitions

Affiliates: Those entities controlled by, controlling, or under common control with Hospital. For purposes of this policy, the term “Affiliates” does not include Hospital affiliates that are legally or otherwise restricted from adopting this policy.

Amounts Generally Billed: Charges for medically necessary services shall be limited to no more than amounts generally billed to individuals who have insurance covering such care (“AGB”).

- i. In calculating the AGB, the Hospital has selected the “look-back” method whereby the AGB is determined based on actual past claims paid to the Hospital by Medicare fee-for-service together with all private health insurers paying claims to the Hospital.
- ii. The AGB percentage will be calculated at least annually by dividing the sum of all claims that have been paid in full during the prior 12 month period by the sum of the gross charges for those claims. This resulting percentage is then applied to an individual’s gross charges to reduce the bill.
- iii. A revised percentage will be calculated and applied by the 45th day after the first day of the start of the fiscal year used to determine the calculations.

Applicant: An Applicant is the person submitting an Application for Financial Assistance, including the patient and/or the patient’s guarantor.

Application: A Financial Assistance Application.

Application Period: During the Application Period, the Hospital must accept and process an application for Financial Assistance (“Application”). The Application Period begins on the date the care is provided to the individual and ends on the 240th day after the Hospital provides the patient with the first billing statement for the care.

Billed Charge(s): The fee for a service that is based on the Hospital’s master charge schedule in effect at the time of the service.

Completion Deadline: The Completion Deadline is the date after which a Hospital may initiate or resume ECAs (as defined below) against an individual who has submitted an incomplete Application if that individual has not provided the Hospital with the missing information and/or documentation necessary to complete the Application. The Completion Deadline must be no earlier than the later of 30 days after the Hospital provides the individual with this written notice; or the last day of the Application Period.

Cost-of-Care Discount: 30%

Discounted Care: Care provided at less than Billed Charges other than Free Care. Discounts include the Cost-of-Care Discount and the Managed Care Discount.

Extraordinary Collection Activity: As defined by the Act, but includes any legal action with respect to a Patient’s Account.

Family Income: Family Income is defined based on definitions used by the U.S. Bureau of the Census and includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as SNAP and housing subsidies) are not considered income.

Family Size: The number of individuals listed under "Filing Status" on the Applicant's most recent tax return. If no tax return is available, Family Size shall be the number of individuals permanently residing in the Applicant's household. If another individual claims the Applicant as a dependent on the individual's tax return, then the Family Size shall include household members of the individual claiming dependency.

Federal Poverty Guideline: The Federal Poverty Guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of 42 USC 9902(2). Guidelines, attached as Appendix A-1, shall be adjusted annually within thirty (30) days following the issuance of new Federal Poverty Guidelines in the Federal Register and on the U.S. Department of Health and Human Services website.

Financial Assistance: Care provided to patients who meet Hospital's criteria for Financial Assistance under various programs (collectively, "Financial Assistance Program" or "Program") and are unable to pay for all or a portion of their health care services. Financial Assistance does not include bad debt or uncollectible charges that have been recorded as revenue but written off due to a patient's failure to pay, or the cost of providing that care to patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived from those programs; or contractual adjustments with any third-party payors.

Free Care: A discount equal to one hundred percent (100%).

Financial Assistance Policy Committee: That committee comprised of representatives from Hospital and which makes recommendations with respect to this Policy and ensures operational alignment in implementing this Policy. If the Hospital does not have a specific committee, the CFO or his/her delegates will address this function.

Household Income: The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. More specifically, Household Income is equal to the adjusted gross income listed on the Applicant's most recent tax return, adjusted to subtract child support payments and to add amounts of tax-exempt interest; non-taxable pension and annuity payments, IRA distributions, and social security; and other income not included in adjusted gross income but available to Applicant. However, if the Applicant indicates that the adjusted gross income listed on the Applicant's most recent tax return is not accurate (e.g., the Applicant is no longer employed or is being paid a different amount), the Household Income shall be calculated on the basis of other available documentation (e.g., pay stubs, unemployment statements, etc.), once again adjusted to remove child support payments and to include tax-exempt interest; non-taxable pension and annuity payments, IRA distributions, and social security; and other income available to Applicant. Household Income includes the income of all members of the household.

Illinois Resident: An Illinois Resident includes patients who qualify for Illinois residency under the Illinois Hospital Uninsured Patient Discount Act (“HUPDA”). HUPDA requires that the Uninsured Patient be a resident of Illinois, but does *not* require that the patient be legally residing in the United States. Patients may be required to provide evidence of Illinois residency as provided for under HUPDA. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this definition. These patients are encouraged to seek treatment at an appropriate facility within their geographic proximity.

Insured Patient: A patient covered under a policy of health insurance or a beneficiary under public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers’ compensation, accident liability insurance, or other third-party liability.

Legal Illinois Resident: A Legal Illinois Resident includes patients legally residing within the United States *and* who have their principal residence within the state of Illinois. With respect to foreign nationals, “legally residing” shall include individuals who have current visas and who are permanent residents and temporary workers. “Legally residing” shall not include foreign nationals who have visitor or student visas. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this definition. These patients are encouraged to seek treatment at an appropriate facility within their geographic proximity.

Medically Necessary: Any inpatient or outpatient health care service, including pharmaceuticals or supplies, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the Patient. A “Medically Necessary” service does not include any of the following: (1) non-medical services such as social and vocational services; or (2) elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness or congenital defect or deformity.

Non-Resident: A Non-Resident is a patient who is neither a Legal Illinois Resident nor an Illinois Resident.

Uninsured Patient: A patient not covered under a policy of health insurance or who is not a beneficiary under public or private health insurance, health benefit, or other health coverage program, including high-deductible health insurance plans, workers’ compensation, accident liability insurance, or other third-party liability.

Appendix A (continued)
Financial Assistance Program Application

CROSSROADS COMMUNITY HOSPITAL

**HOSPITAL FINANCIAL ASSISTANCE APPLICATION
UNDER THE FAIR PATIENT BILLING ACT**

YOU MAY BE ELIGIBLE TO RECEIVE FREE OR DISCOUNTED CARE

Completing this application will help Crossroads Community Hospital determine if you are eligible for Discounted or Free Care or other public programs or governmental health care programs that can help pay for your healthcare. Please submit this application to the hospital. **IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE.** However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs. Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care. Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance. **NOTE:** The requirement to complete and submit this form within 60 days following the date of discharge or receipt of outpatient care referenced in the Opening Statement may be increased by the hospital, but may not be decreased. The Discounted Care or Free Care options only apply to Medically Necessary health care services. The Act does not apply to elective cosmetic surgery or non-medical services such as social and vocational services. If you have questions about what is a Medically Necessary services our financial counselors can assist you in answering them. You are presumptively eligible for Free Care if you meet certain eligibility requirements, including Women, Infants and Children Nutrition program, Supplemental Nutrition Assistance program, Illinois Free Lunch and Breakfast program, Low Income Home Energy Assistance Program, enrollment in an organized community based program providing access in medical care that assess and documents limited low income financial status as a criterion for membership, receipt of grant assistance for medical services, subsidized school lunch and/or low income housing. If you meet the presumptive eligibility criteria or are otherwise presumptively eligible by virtue of you or your family's income, you shall not be required to complete the portions of the application monthly expense information and estimated expenses (see page 14). The Discount Care and/or Free Care entitled do not apply to physician services. You are entitled to apply for financial assistance within sixty (60) days from your date of discharge from inpatient or outpatient services.

Your failure to cooperate with the Hospital, including providing the information available to verify your participation in any of the above programs, failure to provide financial information as requested in this application regarding you or your family, and your failure to cooperate in enrolling in any governmental or similar financial assistance or insurance program for which it is determined you may reasonably be entitled may result in your being denied Financial Assistance to which you otherwise would be entitled. This information must be provided within thirty (30) days of receipt of an application. If you request Financial Assistance, the Hospital must notify

you within thirty days of receipt of all information required as to whether you qualify and if it cannot make that determination within that time frame must notify you why and what if any information is missing from your application.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE.

However, a Social Security Number may be required for some public programs.

FINANCIAL ASSISTANCE / FEDERAL POVERTY GUIDELINE (FPL)

Family Size	FPG	Financial Assistance Cap
1	11,670	35,010
2	15,730	47,190
3	19,790	59,370
4	23,850	71,550
5	27,910	83,730
6	31,970	95,910
7	36,030	108,090
8	40,090	120,270

Effective date for use 01/22/14 (publication date)

For families with more than eight members, add \$4,060.00 for each additional member

Please complete this form and submit it to the Hospital in person, by mail, by electronic mail or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care. The requirement to complete this form within sixty days of discharge or your receipt of outpatient care may be extended by the Hospital, but may not be decreased.

HOSPITAL FINANCIAL ASSISTANCE APPLICATION

Patient Name

Patient's Date of Birth

Account Numbers

Account Balances

Patient's Address

Patient's Phone Number

Patient's City, State & Zip Code

Patient's Email Address

Is the applicant a resident of Illinois	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Was the services provided related to an accident	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Was the services provided work related	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Was the patient a victim of a crime	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

HOUSEHOLD MEMBERS (list all persons living in the household)

Name	Date of Birth	Relationship to Patient

Income Verification

(list all persons in household who are employed)

Name	Employer Name & Location	Employer Phone Number	Monthly Income

Other Income
(list monthly amounts for each household member)

Name	Wages	Unemployment Work Comp	TANF	Social Security	SSI	VA	Child Support/ Alimony

Is there any other income in the family? Yes No

If yes, list source and monthly amount: _____

Total Household Income for the Last Twelve Months? \$ _____

Assets

	Yes	No	Account #	Value	Name of Owner
Home					
Other Property					
Auto 1					
Auto 2					
Checking Acct					
Savings Acct					
Cert. of Deposit					

Stocks/Bonds					
Health Saving Plan/Flex Spending Account					
Other					

Expenses

Housing	
Utilities	
Food	
Transportation	
Child Care	
Loans	
Medical Expenses	
Other Expenses	

Certification

“I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this Hospital bill. I understand that the information provided may be verified by the Hospital, and I authorize the Hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the bill.”

Applicant’s Signature: _____

Date: _____

Hospital Agent: _____

Date: _____

Appendix B

Under Section 10 of the Hospital Uninsured Patient Discount Act, certain personal property is exempt from the determination of assets owned by an eligible uninsured patient as it relates to the maximum collectible amount in a 12 month period (25% of annual income.) Those assets are listed in the Code of Civil Procedure, 735 ILCS 5/12-1001, with reference to a "debtor's" assets. They include the following:

- (a) The necessary wearing apparel, bible, school books, and family pictures of the debtor and the debtor's dependents;
- (b) The debtor's equity interest, not to exceed \$4,000 in value, in any other property;
- (c) The debtor's interest, not to exceed \$2,400 in value, in any one motor vehicle;
- (d) The debtor's equity interest, not to exceed \$1,500 in value, in any implements, professional books, or tools of the trade of the debtor;
- (e) Professionally prescribed health aids for the debtor or a dependent of the debtor;
- (f) All proceeds payable because of the death of the insured and the aggregate net cash value of any or all life insurance and endowment policies and annuity contracts payable to a wife or husband of the insured, or to a child, parent, or other person dependent upon the insured, whether the power to change the beneficiary is reserved to the insured or not and whether the insured or the insured's estate is a contingent beneficiary or not;
- (g) The debtor's right to receive:
 - (1) a social security benefit, unemployment compensation, or public assistance benefit;
 - (2) a veteran's benefit;
 - (3) a disability, illness, or unemployment benefit; and
 - (4) alimony, support, or separate maintenance, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor.
- (h) The debtor's right to receive, or property that is traceable to:
 - (1) an award under a crime victim's reparation law;
 - (2) a payment on account of the wrongful death of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor;
 - (3) a payment under a life insurance contract that insured the life of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor or a dependent of the debtor;
 - (4) a payment, not to exceed \$15,000 in value, on account of personal bodily injury of the debtor or an individual of whom the debtor was a dependent; and

- (5) any restitution payments made to persons pursuant to the federal Civil Liberties Act of 1988 and the Aleutian and Pribilof Island Restitution Act,

For purposes of this subsection (h), a debtor's right to receive an award or payment shall be exempt for a maximum of 2 years after the debtor's right to receive the award or payment accrues; property traceable to an award or payment shall be exempt for a maximum of 5 years after the award or payment accrues; and an award or payment and property traceable to an award or payment shall be exempt only to the extent of the amount of the award or payment, without interest or appreciation from the date of the award or payment.

(i) The debtor's right to receive an award under Part 20 of Article II of this Code relating to crime victims' awards.

(j) Moneys held in an account invested in the Illinois College Savings Pool of which the debtor is a participant or donor, except the following non-exempt contributions:

(1) any contribution to such account by the debtor as participant or donor that is made with the actual intent to hinder, delay, or defraud any creditor of the debtor;

(2) any contributions to such account by the debtor as participant during the 365 day period prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986, as amended, in effect at the time of contribution; or

(3) any contributions to such account by the debtor as participant during the period commencing 730 days prior to and ending 366 days prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986, as amended, in effect at the time of contribution.

For purposes of this subsection (j), "account" includes all accounts for a particular designated beneficiary, of which the debtor is a participant or donor. Money due the debtor from the sale of any personal property that was exempt from judgment, attachment, or distress for rent at the time of the sale is exempt from attachment and garnishment to the same extent that the property would be exempt had the same not been sold by the debtor if a debtor owns property exempt under this Section and he or she purchased that property with the intent of converting nonexempt property into exempt property or in fraud of his or her creditors, that property shall not be exempt from judgment, attachment, or distress for rent. Property acquired within 6 months of the filing of the petition for bankruptcy shall be presumed to have been acquired in contemplation of bankruptcy. The personal property exemptions set forth in this Section shall apply only to individuals and only to personal property that is used for personal rather than business purposes. The personal property exemptions set forth in this Section shall not apply to or be allowed against any money, salary, or wages due or to become due to the debtor that are required to be withheld in a wage deduction proceeding under Part 8 of this Article XII.