Financial Assistance Application

Tufts Medical Center

Tufts Medical Center takes pride in providing the best care for every patient. Tufts MC offers financial assistance through its Financial Assistance Policy to patients unable to pay for emergency and medically necessary care. Tufts MC Financial Assistance is not intended to cover non-medically necessary care. It is also not intended to provide discounts on insurance co-payments, co-insurance, or deductibles.

Patients who have the means are expected to pay for services received at Tufts MC. However, eligibility for financial assistance is available to you. Patients are strongly encouraged to apply for any available government assistance programs, such as MassHealth, ConnectorCare, or Health Safety Net, before applying for the Tufts MC Financial Assistance Program. **Failure to apply for a government assistance program that you potentially qualify for could result in a delay or denial of your application.** If you need help applying for government assistance programs, one of our Tufts MC Financial Coordinators can help.

Your qualification for financial assistance programs is dependent upon your full and accurate completion of this Financial Assistance Application.

For questions, please contact the Tufts MC Financial Coordination Department at:

tuftsmedicalcenter.org/financialassistance

617-636-6013

or in person at the following Tufts Medical Center locations:

- **Biewend Building, 1st Floor**
  260 Tremont Street
  Boston, MA 02111
- **Proger Building, 1st Floor**
  800 Washington Street
  Boston, MA 02111
- **Emergency Dept., 1st Floor**
  800 Washington Street
  Boston, MA 02111

INSTRUCTIONS

Please fully complete the Financial Assistance Application and include copies of the following documents for all applicants. Failure to return all necessary documents within 30 days will cause the application to be denied. Please attach copies of any documents submitted as unfortunately they cannot be returned.

- ☐ Complete all applicable sections of the application and be sure to **sign the affidavit statement on page 4**
- ☐ Include a copy of your **driver's license, other photo identification or documents that verify your current residence.** Anything submitted must include your name.
- ☐ Include a copy of your **insurance card(s)**
- ☐ Include some form of **income verification:**
  - ☐ Include a copy of your most recent **W-2(s)**
  - ☐ If there has been a **recent change in your income,** include documentation such as recent pay stubs (minimum 4), unemployment statements, bank/investment statements, and/or social security statements
- ☐ If the patient is **deceased,** please provide a copy of the death certificate and a letter stating the status of the estate

Please send your completed application to:

Tufts Medical Center
Financial Coordination
800 Washington Street, Box 475
Boston, MA 02111

1 ABOUT THE PATIENT/APPLICANT

Please complete this section about the patient and/or applicant.

DOCUMENTATION REQUIRED: Please include documentation that verifies residency: driver's license, other photo identification or documents that prove your current residence. Anything submitted must include patient's name.

The applicant is either the patient or the person who is financially responsible for the patient.

Today's Date _____

Patient Name _____

Patient Date of Birth __/__/____

DOB Format: MM/DD/YYYY

Patient Soc. Sec. No. ___/__/____

Patient Medical Rec. No. _____

Applicant Name _____

Applicant Phone _____

Applicant Address _____

ABOUT YOUR HOUSEHOLD

List all household members, their date of birth and relationship to the applicant.

Household Member 1 _____

Date of Birth __/__/____

Relationship to Patient _____

Household Member 2 _____

Date of Birth __/__/____

Relationship to Patient _____

Household Member 3 _____

Date of Birth __/__/____

Relationship to Patient _____

Household Member 4 _____

Date of Birth __/__/____

Relationship to Patient _____

Household Member 5 _____

Date of Birth __/__/____

Relationship to Patient _____

☐ **Yes** ☐ **No** Are you a citizen of the United States?

☐ **Yes** ☐ **No** If NO, are you a permanent resident, legally residing in the US*?
*if patient is a permanent resident, provide a copy of official documentation.

2 INSURANCE INFORMATION

Please complete this section about the patient's insurance.

DOCUMENTATION REQUIRED: If applicable, please include a copy of the patient's insurance card(s), notifications from Medicaid, notification of non-covered services, documentation of network limitations. Anything submitted must include the patient's name.

☐ **Yes** ☐ **No** Have you submitted a Medicaid application within last 6 months?

☐ **Yes** ☐ **No** Do you have a pending or approved Medicaid application?

☐ **Yes** ☐ **No** Has your Medicaid application been denied?

☐ **Yes** ☐ **No** Do you have medical insurance?

☐ **Yes** ☐ **No** Does your plan cover services at Tufts Medical Center?

☐ **Yes** ☐ **No** Is a specific service not covered by your insurance company?

If yes, please describe _____

_____

_____

PRIMARY INSURANCE INFORMATION

Insurance Name _____

Insurance Address _____

Policy/ID # _____

Group# _____

Subscriber _____

Subscriber Date of Birth __/__/____

Relationship to Subscriber _____

Subscriber Employer _____

Effective Date __/__/____

SECONDARY INSURANCE INFORMATION

Insurance Name _____

Insurance Address _____

Policy/ID # _____

Group# _____

Subscriber _____

Subscriber Date of Birth __/__/____

Relationship to Subscriber _____

Subscriber Employer _____

Effective Date __/__/____

3 MONTHLY GROSS INCOME AND ASSETS

Please complete this section about earned income and assets for patient and each household member listed in Section 1 who works. Please list gross income, which is income before taxes and deductions.

DOCUMENTATION REQUIRED: Please include documentation that verifies this income: pay stubs, income taxes, W2 statement, bank statements, brokerage statements, or other proof.

Section 3 can be left blank if the patient and his/her household members do not have any earned income or assets.

HOUSEHOLD INCOME

	PATIENT	HOUSEHOLD MEMBER 1	HOUSEHOLD MEMBER 2	HOUSEHOLD MEMBER 3	HOUSEHOLD MEMBER 4	(FACILITY USE ONLY)
Wages/Salary/Tips						
Unemployment Compensation						
Social Security						
Child Support + Alimony						
Self-Employment Income						
Interest/Dividend Income						
Pension						
IRA/Stocks/Bonds						
Rental Income						
Trust Payments						
Workers Compensation						
Veteran Benefits						

LACK OF INCOME STATEMENT

If you have **no income** and are being financially supported by another person, please have them complete and sign the below statement.

Patient Name _____

currently has no income. I am currently supporting them with food, shelter and any clothing needed. I also give them financial help in the amount of

$_____ on average per month.

Support Giver's Signature _____

Date __/__/____

HOUSEHOLD ASSETS—CHECKING AND SAVINGS ACCOUNTS

TYPE OF ACCOUNT	BANK/INSTITUTE	BALANCE

Type of account: checking or savings.

Section 3 continued page 5

OTHER HOUSEHOLD COUNTABLE ASSETS

TYPE OF ACCOUNT	BANK/INSTITUTE	BALANCE
Stocks/Bonds		
Certificate of Deposit		
US Savings Bonds		
Health Savings Account (HSA)		
Savings Certificate		
Christmas or Vacation Clubs		
Other		

4 MEDICAL HARDSHIP

This section may not be applicable to you. Please complete this section if you have significant medical bills. List healthcare expenses from Tufts Medical Center and other providers. Documentation may be requested but is not required at this time.

MEDICAL EXPENSES	TOTAL AMOUNT	HOW OFTEN DOES THE COST OCCUR?	(FACILITY USE ONLY)
		☐ Weekly ☐ Monthly ☐ Yearly	
		☐ Weekly ☐ Monthly ☐ Yearly	
		☐ Weekly ☐ Monthly ☐ Yearly	
		☐ Weekly ☐ Monthly ☐ Yearly	
		☐ Weekly ☐ Monthly ☐ Yearly	
		☐ Weekly ☐ Monthly ☐ Yearly	

AFFIDAVIT — ALL APPLICANTS MUST SIGN

I swear (or affirm) that all the information indicated on this form is true, correct and complete to the best of my ability, knowledge and belief. I agree to report to Tufts Medical Center, within one week, all changes in income, financial resources or other information indicated on this form which may affect my eligibility to receive financial assistance at Tufts Medical Center. I understand that my credit and other financial information may be referenced to verify my statement and eligibility for the program. I understand that I have 30 days to submit accurate and necessary supporting documentation to be considered for a discount.

Fraudulent statements by the patient for the purpose of obtaining financial assistance will be forwarded to the Massachusetts Attorney General's office. Patients who falsify the Program application will no longer be eligible for the Program and will be held responsible for all charges incurred while enrolled in the Program retroactively to the first day that charges were incurred under the Program.

All applicants must sign the affadavit for their application to be considered.

Applicant's Signature _____

Date __/__/____