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Financial

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Assistance

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Policy

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財務補助政策

Política de Assistência Financeira

Правила предоставления финансовой помощи

Política de Asistencia Financiera

Chính sách Hỗ trợ Tài chính

## I. PURPOSE

Tufts Medical Center, commonly referred to as “Tufts MC” or the “Hospital” throughout this policy, is committed to providing quality healthcare services to the community. The Hospital provides medically necessary services to all patients regardless of their ability to pay. The Hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, gender identity, sexual orientation, age, or disability in providing its services. In order to provide such high quality services and support the needs of its community, Tufts MC must maintain a viable financial foundation that includes the timely collection of its accounts receivable.

Tufts MC recognizes that some patients have limited means and may not have access to insurance coverage for all services. This policy has been developed to inform uninsured and underinsured patients with limited financial resources of the various Hospital financial assistance programs that might be available to them.

Patients who have the means are expected to pay for services provided by Tufts MC. This policy assumes that patients who have access to affordable insurance will apply for and maintain their coverage. Tufts MC financial assistance programs are intended to primarily serve patients who do not have health insurance from either a public (e.g., Medicare or Medicaid) or private (e.g., Blue Cross Blue Shield, Harvard Pilgrim, etc.) source and have an unmet financial need. If applicable criteria are met, Tufts MC discounts may be available to patients with demonstrated financial need either due to limited income or if their medical bills are an excessive portion of their income.

## II. DEFINITIONS

*Emergency Services:* medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395dd(e)(1)(B). A medical screening examination and any stabilizing treatment for an emergency medical condition, including but not limited to inpatient medical care or any other such service rendered to the extent required under the Emergency Medical Treatment and Labor Act (EMTALA) (42 U.S.C. § 1395(dd)), qualifies as Emergency Services.

*Urgent Services:* medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing the patient’s health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual’s health.

*Medically Necessary Non-Emergency, Non-Urgent Services:* services that do not meet the definition of Emergency or Urgent services but that are medically necessary. The patient typically, but not exclusively, schedules these services in advance.

*Non-Medically Necessary Services:* a procedure, test, or service that does not impact the quality of health or require emergency or urgent care to be rendered.

## III. GENERAL PROVISIONS

### a. Participating Entities

This policy applies to services delivered and billed by the Hospital at the locations set forth in Appendix A—Tufts Medical Center Locations, Participating Entities. This policy does not apply to services delivered and billed by the entities listed in Appendix B—Tufts Medical Center Provider Affiliate List, Non-Participating Entities even in the case where such services may be rendered in the Hospital locations set forth in Appendix A.

- b. Tufts MC Uninsured and Underinsured Patients are defined as:
  - 1. Patients with no health insurance (“uninsured”);
  - 2. Patients whose only “insurance” is the Massachusetts Health Safety Net;
  - 3. Patients who have balances resulting from having “exhausted” benefits under their insurance plan; or
  - 4. Patients whose balance results from “non-covered” services where insurance has determined that the patient is fully responsible for the charges associated with the excluded services. This includes services where the insurer denied coverage due to the insurer’s network limitation.
- c. Patient Responsibilities:
  - i. The patient has a number of responsibilities to meet in order to qualify for assistance from the Hospital under this policy, including:
    - 1. Obligation to obtain and maintain insurance coverage, if affordable coverage is available to them;
    - 2. Obligation to apply for any government-sponsored insurance program they may qualify for;
    - 3. Obligation to submit, in a timely manner, all requested documentation of income, assets, identity, and residency that is required to enroll in State coverage and/or to complete the Tufts MC Financial Assistance Application;
    - 4. Obligation to keep the Hospital apprised of current demographic and insurance information; and
    - 5. Obligation to pay all balances in accordance with agreed upon time frames.
- d. Tufts MC Financial Coordination Procedure:
  - i. Financial Coordination (FC) proactively reviews identifiable uninsured and underinsured patients scheduled for service. Patients are also referred to FC from Tufts MC departments.
  - ii. FC screens patients for eligibility for public and/or private insurance coverage
    - 1. Tufts MC screens patients for eligible state and federal programs. In order to be eligible for discounts under this policy, patients may be required to apply for a variety of state and federal programs, including but not limited to MassHealth and/or Medicare.
    - 2. If the patient meets public eligibility guidelines, FC will advise on the application process and assist the patient with the application when possible.
    - 3. If the patient does not meet public eligibility guidelines (i.e., based on their Federal Poverty Level (“FPL”), immigration status, etc.), is denied for any available public programs, or if the public program will not fully cover the patient’s costs, FC will advise of private coverage options and screen the patient for eligibility under Tufts MC Financial Assistance Discount Program ([Section IV](#) below).

#### **IV. TUFTS MC PATIENT DISCOUNT PROGRAMS**

- a. Tufts MC offers the following patient discount programs:
  - 1. Low Income Patient Discount, as qualified by Tufts MC FPL thresholds ([Section IV\(g\)](#))
  - 2. Medical Hardship Discount, as qualified by Tufts MC thresholds ([Section IV\(h\)](#))
  - 3. Uninsured and Underinsured Discount ([Section IV\(i\)](#))

Discounts under these programs may be granted to all balance(s) with a patient responsibility that meet Tufts MC determined thresholds in [Appendix C—Tufts Medical Center Financial Assistance Discount Amounts](#), excluding patient co-payments, deductibles, and co-insurance. If patients qualify for multiple discount programs, the program with the highest discount will be given.

Discounts will not be based upon any relationship that the patient or his/her family may have with any Hospital employee or member of the governing body. Discounts will not be extended based upon any consideration of “professional courtesy” for a clinician or his/her family. Discounts will not be offered to patients to induce the patient to receive services or otherwise be linked in any manner to the generation of business payable by a federal healthcare program nor will they be redeemable for cash for items or services provided by the Hospital, or any other Tufts MC entity (this includes discounts to the gift shop, cafeteria, etc.).

- b. Application and Screening Process:
  - i. Patients must submit a completed Tufts Medical Center Financial Assistance Application (Appendix D) along with the necessary supporting documentation in order to be considered for assistance. Necessary documentation may include, but is not limited to proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), (4) assets of those individuals who are 65 and over, and (5) insurance information, including benefit coverage and network limitations. All supporting documentation must be submitted within 30 days of the initial submission of the application in order for the application to be considered by the Hospital.
  - ii. Confidential applications may be submitted to the Hospital for minors and abused individuals. Such individuals should contact Financial Coordination.
  - iii. Tufts MC does not take prior determinations of eligibility for Tufts MC financial assistance into account in making its determination on a patient's Financial Assistance Application.
  - iv. Tufts MC reserves the right to re-verify eligibility for discounts every six months.
- c. Approval for Coverage
  - i. The Hospital will notify patients in writing of Tufts MC program eligibility determinations. Reference Appendix E—Tufts Medical Center Program Eligibility Determination Notifications.
  - ii. The Hospital reserves the right to deny applications if all supporting documentation is not timely received.
  - iii. Appeals of program eligibility determinations may be reconsidered if an applicant provides the Hospital with new information.
- d. Patient Income Limitations:
  - i. For residents of the United States, the most recently published FPLs for the total income of the family will be used as the primary determinant for the discounts described in Section IV(g) and Section IV(h).
  - ii. Non-US residents and US residents who meet the requirements of Section III(c) of this policy but who do not meet FPL qualifying criteria may be entitled to the Uninsured and Underinsured Discount as described in Section IV(i) below.
  - iii. All patients who meet the requirements of Section III(c) of this policy may qualify for a Tufts MC Medical Hardship Discount as outlined in Section IV(h) below.
- e. Eligible Services:
  - i. This policy is generally limited to medically necessary services provided and billed by Tufts MC including:
    - 1. Emergency Services;
    - 2. Urgent Services; and
    - 3. Non-Emergency, Non-Urgent Services.
- f. Exclusions:
  - i. Tufts MC does not provide financial assistance for Non-Medically Necessary Services as such services are determined by the treating clinician. Examples of services that are ineligible for financial assistance from the Hospital include but are not limited to: nonmedical services (e.g., social, educational, or vocational, cosmetic surgery, research or other). The determination of which services are considered eligible for purposes of this policy resides solely with the Hospital.
  - ii. Tufts MC does not generally provide discounts to patients for Non-Emergency, Non-Urgent services where the need for the care was anticipated by the patient and the patient came to Tufts MC from outside its service area to receive care when the services are offered within the patient's service area.
  - iii. Patient co-payments, deductibles, and co-insurance are excluded from coverage under this policy.

- g. Tufts MC Low Income Patient Discount:
  - i. For residents of the United States, the most recently published FPLs for the total income of the family will be used as the primary determinant. Discounts based solely on income are generally limited to patients with family income levels less than 301% of the FPL.
  - ii. Patients who meet this threshold will be offered a discount at or greater than the Amount Generally Billed (AGB) rate as outlined in Section IV(j) below.
  - iii. The determination for this discount is the responsibility of Tufts MC.
  - iv. Reference Appendix C and Appendix D for additional detail.
- h. Tufts MC Medical Hardship Discount:
  - i. Patients who do not meet the FPL thresholds requirements necessary to qualify for the Tufts MC Low Income Patient discount may still qualify for a discount if they can demonstrate that their medical expenses exceed 20% of their family income. Expenses must have occurred within the prior 12 months and are limited to those expenses that could potentially qualify as a medical expense under the Internal Revenue Service regulations.
  - ii. The determination for this discount is the responsibility of Tufts MC.
  - iii. Reference Appendix C and Appendix D for additional detail.
- i. Tufts MC Uninsured and Underinsured Patient Discount Policy:
  - i. Tufts MC will offer a discount to patients of all income levels regardless of residency who meet the qualifications for “Uninsured and Underinsured Patients” listed in Section III(b) above, fulfill the patient responsibilities of Section III(c) above, and who complete a Tufts MC Financial Assistance Application.
  - ii. All Uninsured and Underinsured patients who meet the conditions of this policy are eligible for a discount of up to 20% on Eligible Services if payment is received, or if a payment plan is agreed to, within 30 days of the initial bill.
    - 1. For Non-Emergency, Non-Urgent services, payment must be made in full, or a payment plan agreed to, prior to service delivery. Should actual charges exceed the estimate, the patient must pay any additional amount owed within 30 days of the initial bill.
      - a. If additional charges are not paid in a timely manner, the entire discount agreement may be reversed and the patient will be billed for full charges
    - 2. For Emergency or Urgent services, payment must be made, or a payment plan agreed to, within 30 days of the initial bill.
  - iii. In evaluating whether to grant a discount under this policy, Tufts MC may take into account whether a patient is current on all outstanding balances.
- j. Basis for Calculating Amounts Charged to Patients:
  - i. Following a determination of a patient’s eligibility for the discount programs set forth in Section IV(g) or Section IV(h) above, a patient will not be charged more for Eligible Services than the Amount Generally Billed (“AGB”) by the Hospital.
  - ii. Tufts MC determines the AGB by first dividing the total payments by total charges for all commercial and Medicare fee-for-service (FFS) plans in the aggregate for the prior year to determine the Payment on Account Factor (PAF) for the prior year. The minimum Tufts MC Low Income Patient discount is equal to the inverse of the prior year’s PAF, which is the AGB.
  - iii. For example, inpatient calculation:
    - 1. Total Payment from commercial and Medicare FFS plans: \$550
    - 2. Total Charges for commercial and Medicare FFS plans: \$1,000
    - 3. PAF: 55%
    - 4. Tufts MC Low Income Patient AGB Discount: 45%
  - iv. Tufts MC Low Income Patient Minimum Discount, which is the AGB, is effective 3/1/19 at 49.5% for inpatient and 69.5% for outpatient services. These were determined from commercial and Medicare FFS plans’ paid claims for the period 1/1/18 to 12/31/18.

## V. PAYMENT PLAN

Interest-free payment plans for Eligible Services will be offered to all patients who meet the criteria set forth in Section III(c) above upon request. Final acceptance of a payment plan is subject to a complete review of the patient's status and payment history. Tufts MC will process and monitor all patient payment plans. Full patient compliance is expected if a payment plan is agreed upon. If a patient misses two consecutive payments, the payment plan is terminated and the Hospital may place the account in Bad Debt in accordance with the procedures and protections set forth in the Hospital's Credit and Collection Policy (available at [www.tuftsmedicalcenter.org/financialassistance](http://www.tuftsmedicalcenter.org/financialassistance)). Upon notification from the patient of changed financial circumstances, the Hospital may re-evaluate the patient's outstanding payment obligation.

- a. Patients that have been determined to be a Low Income Patient or eligible for Medical Hardship under the Massachusetts Health Safety Net program are not required to meet the criteria set forth in Section III(c) prior to the Hospital offering a payment plan. For HSN Low Income or Medical Hardship patients with a balance of \$1,000 or less, such payment plan shall be at least a one-year, interest-free plan with a minimum payment of no more than \$25 per month. For HSN Low Income or Medical Hardship patients with a balance of \$1,000 or more, such payment plan shall be at least a two-year, interest free plan.
- b. Patients that are not determined to be Low Income can set up a zero interest monthly payment plan for any bill, even a bill for a health insurance co-payment, co-insurance, or deductible. Payment plans are limited to terms of 1 year for balances up to \$1,000 and two years for balances over \$1,000.

## VI. NONPAYMENT

The Hospital maintains a separate Credit and Collection policy that addresses the actions the Hospital may take in the case of nonpayment and includes a list of patients who may be protected under State law from any collection action. Prior to engaging in any extraordinary collection actions under such policy, the Hospital will make a reasonable effort to qualify a patient for financial assistance under this policy by notifying the patient in writing about the available assistance programs and assisting such individual with the completion of the Tufts MC Financial Assistance application. The Hospital's separate Credit and Collection policy is readily available to members of the public on the Hospital's website at [www.tuftsmedicalcenter.org/financialassistance](http://www.tuftsmedicalcenter.org/financialassistance).

## VII. PUBLICATION AND DISSEMINATION OF THE FAP

- a. Tufts MC Financial Coordination Department, who offers financial counseling and financial assistance, may be reached:
  - i. Online at [www.tuftsmedicalcenter.org/financialassistance](http://www.tuftsmedicalcenter.org/financialassistance);
  - ii. By telephone at 617-636-6013; or
  - iii. In person at the following Tufts Medical Center locations:
    1. Biewend Building, 1st Floor, 260 Tremont Street, Boston, MA 02111
    2. Proger Building, 1st Floor, 800 Washington Street, Boston, MA 02111
    3. Emergency Department, 1st Floor, 800 Washington Street, Boston, MA 02111
- b. Internet Posting
  - i. In addition to being available through Tufts MC Financial Coordination, the Tufts MC Financial Assistance policy, application forms, and a plain language summary are available at: [www.tuftsmedicalcenter.org/financialassistance](http://www.tuftsmedicalcenter.org/financialassistance)
    1. This website may also be accessed from the Tufts MC homepage ([www.tuftsmedicalcenter.org](http://www.tuftsmedicalcenter.org)) by selecting *Patient Care + Services*, then select *Financial Assistance*
    2. The website includes various ways in which patients can apply for assistance from the Hospital, including a list of Financial Coordination locations, a central phone number, and a central email address. The website lets patients know that the application forms and Financial Coordination assistance are free.
- c. The Hospital widely publicizes the availability of financial assistance under this policy in the following ways:
  - i. Large, conspicuous signage (8" X 14") is posted in all portals of entry and other high traffic areas, including the Emergency Department, Financial Coordination and Customer Service;

- ii. Plain language brochures that advertise the availability of Tufts MC financial assistance options are displayed in the Emergency Department and admission areas.
- iii. The plain language summary of the FAP is available to patients as part of the Hospital's intake and discharge process.
- iv. Copies of the Hospital's FAP policy, application, plain language summary are made available to patients that request a copy, in person or by mail and for any patient who has specific questions.
- v. Materials, including the policy, application form, and plain language summary are available in English, Chinese, Spanish, Vietnamese, Portuguese-Continental, and Russian.
- vi. Hospital community program staff are educated about the FAP and are instructed to inform and notify their community constituents of the availability of financial assistance at Tufts MC.

#### **VIII. OTHER PROVISIONS:**

##### a. Medicare Bad Debt:

- i. This policy may also be used to verify the indigence of a patient for the purposes of qualifying their balances resulting from a co-insurance or deductible from services covered by Medicare where Medicare Bad Debt is applicable. The determinants will be the patient's current income of their reported asset levels. To qualify, the patient must have an income of less than 201% of the FPL and assets of less than \$10,000 for the first family member with an additional \$3,000 allowed for each additional family member. Asset determinations will never include the primary residence or the primary automobile. The patient's completion of a Tufts MC Financial Assistance Application will be proof that the patient has an inability to use assets to pay their outstanding balances.

##### b. Case-By-Case Evaluation:

- i. Patients are encouraged to bring their unique financial situations to the attention of Financial Coordination or Patient Financial Services. Tufts MC may extend discounts beyond the provisions in this policy on a case-by-case basis to recognize unique cases of financial hardship.
- ii. Existing discounts that go beyond this policy may be honored with the approval of the Hospital CFO.

## **APPENDIX A**

### **TUFTS MEDICAL CENTER LOCATIONS, PARTICIPATING ENTITIES**

This policy applies to the services delivered and billed by Tufts MC at the following locations:

1. Tufts Medical Center  
800 Washington Street, Boston, MA 02111
2. Floating Hospital for Children at Tufts Medical Center  
800 Washington Street, Boston, MA 02111
3. South Boston Day Hospital  
58 Old Colony Avenue, Boston, MA 02111
4. Tufts Medical Center Mobile MRI at Lemuel Shattuck Hospital  
170 Morton Street, Jamaica Plain, MA 02130
5. Tufts Medical Center Imaging – Norfolk  
31 Pine Street, Norfolk, MA 02056
6. Tufts Medical Center Cancer Center  
41 Montvale Avenue, 3rd and 5th Floors  
Stoneham, MA 02180



## **APPENDIX B**

### **TUFTS MEDICAL CENTER PROVIDER AFFILIATE LIST, NON-PARTICIPATING ENTITIES**

This policy excludes services delivered and billed by the following entities associated with Tufts MC:

#### **1. Tufts Medical Center Physicians Organization, including:**

- a. Pratt Medical Group, Inc. (Cardiology, Endocrine, Gastroenterology, Hematology/Oncology, Infectious Disease, Internal Medicine, Nephrology, Nutrition, Pulmonary, Rheumatology)
- b. Pratt Orthopaedic Associates, Inc.
- c. New England Medical Center Group Practice, Inc. (DBA Neurosurgery)
- d. Pratt Anesthesiology Associates, Inc.
- e. Pratt Medical & Surgical Dermatology Associates, Inc.
- f. Pratt Otolaryngology Head & Neck Surgery Associates, Inc. (Ear, Nose, and Throat)
- g. Pratt Neurology Associates, Inc.
- h. Pratt OB GYN Associates, Inc.
- i. Pratt Ophthalmology Associates, Inc. (DBA New England Eye Center)
- j. Pratt Pathology Associates, Inc.
- k. Pratt Pediatric Associates, Inc.
- l. Pratt Psychiatric Associates, Inc.
- m. Pratt Radiology Associates, Inc.
- n. Pratt Radiation Oncology Associates, Inc.
- o. Pratt Rehabilitation Medicine Associates, Inc.
- p. Pratt Surgical Associates, Inc.
- q. Pratt Urology Associates, Inc.
- r. CardioVascular Center at Tufts Medical Center

#### **2. Tufts Medical Center EP, LLC — Tufts MC Emergency Department Physicians located at 800 Washington Street, Boston, MA 02111**

#### **3. Tufts University School of Dental Medicine**

#### **4. Orthopedic and Sports Physical Therapy, Boston – Physical Therapy located on Biewend 7, 260 Tremont Street, Boston, MA 02116**

#### **5. Outside Plastic Surgeons**

- a. Richard Bartlett, MD
- b. Rita Sadowski, MD

#### **6. Private Practice Internal Medicine located on Biewend 1, 260 Tremont Street, Boston, MA 02116**

- a. Maria Gorbovitsky, MD
- b. Yun Lam, MD

All physician organizations associated with Tufts MC including the ones set forth above are encouraged, but not required, to follow this policy.

**APPENDIX C**

**TUFTS MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM: DISCOUNT AMOUNTS**

<b>Family Size</b>	<b>100% FPL</b>	<b>Up to 150% FPL</b>	<b>Up to 300% FPL</b>	<b>Greater than 301% FPL</b>
1	\$12,492	\$18,744	\$37,476	\$37,477
2	\$16,920	\$25,368	\$50,736	\$50,737
3	\$21,336	\$32,004	\$63,996	\$63,997
4	\$25,752	\$38,628	\$77,256	\$77,257
5	\$30,180	\$45,264	\$90,516	\$90,517
6	\$34,596	\$51,888	\$103,776	\$103,777
7	\$39,012	\$58,524	\$117,036	\$117,037
8	\$43,440	\$65,148	\$130,296	\$130,297
Each person >8	\$4,428	\$6,636	\$13,260	\$13,261
Inpatient Discount	100%		49.5%	20%
Outpatient Discount			69.5%	
Expected Inpatient Patient Payment	0%		50.5%	80%
Expected Outpatient Patient Payment			30.5%	

FPL is defined as Federal Poverty Level, released January 2019, as defined by the Federal Register.

## Financial Assistance Application



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.

### ■ 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

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

[tuftsmedicalcenter.org/financialassistance](https://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

Please send your completed application to:

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

**APPENDIX D: TUFTS MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION**

**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.

**APPENDIX D: TUFTS MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION**

**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   /  /

**APPENDIX D: TUFTS MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION**

**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.

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

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

**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

**APPENDIX D: TUFTS MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION**

**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)
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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.

Applicant's Signature \_\_\_\_\_

Date     /    /    

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

**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

*The principal teaching  
hospital for Tufts University  
School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Approval Letter—Partial Discount]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

Thank you for your application for assistance with your bills under the Tufts Medical Center Financial Assistance Program (the “Program”). We have reviewed your application and supporting documentation and have determined that, based on your income, you are eligible for reduced-charge services under the Program.

We have determined that your income is \_\_\_\_\_ for your family size of \_\_\_\_\_, which qualifies you to pay only \_\_\_\_\_ of our usual charge. Bills of \_\_\_\_\_ for services received by \_\_\_\_\_ on \_\_\_/\_\_\_/\_\_\_ are being reduced to \_\_\_\_\_. We will contact you to assist you with making arrangements for payments on the remaining balance of the bill and will send you a detailed bill upon request. Please note the discount under this Program does not apply to any co-payment, co-insurance or deductible amounts that continue to be your responsibility.

This approval shall be in effect for a period of six (6) months. If you disagree with this decision and believe you qualify for a further reduction in your charges, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone



**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

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hospital for Tufts University  
School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Approval Letter—100% Discount]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

Thank you for your application for assistance with your bills under the Tufts Medical Center Financial Assistance Program (the "Program"). We have reviewed your application and supporting documentation and have determined that, based on your income, you are eligible for services at no cost to you under the Program. We are therefore writing off bills of \_\_\_\_\_ for services received by \_\_\_\_\_ on \_\_/\_\_/\_\_\_\_. You should not receive any further bills from us for these services.

This approval shall be in effect for a period of six (6) months. If you have any questions, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone

**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

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School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Redetermination Letter—Partial Discount to 100% Discount]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

We write in follow up to our original determination on \_\_/\_\_/\_\_\_\_ that you were only eligible for reduced charges under the Tufts Medical Center Financial Assistance Program (the "Program"). At your request, we have reconsidered our original decision on your application and have determined that, based on your income, you are eligible for services at no cost to you under the Program. We are therefore writing off bills of \_\_\_\_\_ for services received by \_\_\_\_\_ on \_\_/\_\_/\_\_\_\_. You should not receive any further bills from us for these services. This approval shall be in effect for a period of six (6) months. If you have any questions, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone

**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

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School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Redetermination Letter—Not Previously Eligible to 100% Discount]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

We write in follow up to our original determination that you were not eligible for financial assistance under the Tufts Medical Center Financial Assistance Program (the "Program"). At your request, we have reconsidered our original decision on your application and have determined that, based on your income, you are eligible for services at no cost to you under the Program. We are therefore writing off bills of \_\_\_\_\_ for services received by \_\_\_\_\_ on \_\_/\_\_/\_\_\_\_. You should not receive any further bills from us for these services. This approval shall be in effect for a period of six (6) months. If you have any questions, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone

**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

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hospital for Tufts University  
School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
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[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Redetermination Letter—Not Eligible to Partial Discount]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

We write in follow up to our original determination that you were not eligible for financial assistance under the Tufts Medical Center Financial Assistance Program (the "Program"). At your request, we have reconsidered our original decision and have determined that, based on your income, you are eligible for reduced-charge services under the Program.

We have determined that your income is \_\_\_\_\_ for your family size of \_\_\_\_\_, which qualifies you to pay only \_\_\_\_\_ of our usual charge. Bills of \_\_\_\_\_ for services received by \_\_\_\_\_ on \_\_\_/\_\_\_/\_\_\_ are being reduced to \_\_\_\_\_. We will contact you to assist you with making arrangements for payments on the remaining balance of the bill and will send you a detailed bill upon request. Please note the discount under this Program does not apply to any co-payment, co-insurance or deductible amounts that continue to be your responsibility.

This approval shall be in effect for a period of six (6) months. If you disagree with this decision and believe you qualify for a further reduction in your charges, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone

**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

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School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Redetermination Letter—Original Decision Stands—Partial]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

We write in follow up to our original determination on \_\_/\_\_/\_\_ that you were only eligible for reduced charges under the Tufts Medical Center Financial Assistance Program (the "Program"). At your request, we have reconsidered our original decision on your application and have determined that, based on your income, you continue to only be eligible for a partial discount under the Program.

As noted in our original determination letter, bills of \_\_\_\_\_ for services received by \_\_\_\_\_ on \_\_/\_\_/\_\_ are being reduced to \_\_\_\_\_. We will contact you to assist you with making arrangements for payments on the remaining balance of the bill and will send you a detailed bill upon request. Please note the discount under this Program does not apply to any co-payment, co-insurance or deductible amounts that continue to be your responsibility.

This approval shall be in effect for a period of six (6) months. If you continue to disagree with this decision, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone

**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

*The principal teaching  
hospital for Tufts University  
School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Redetermination Letter—Original Decision Stands Not Eligible]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

We write in follow up to our original determination on \_\_/\_\_/\_\_\_\_ that you were not eligible for assistance under the Tufts Medical Center Financial Assistance Program (the “Program”). At your request, we have reconsidered our original decision on your application and have determined that, based on your income, you are not eligible for assistance under the Program.

If you continue to disagree with this decision or would like to discuss payment arrangement options, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone

**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

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School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Denial Letter—General]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

Thank you for your application for assistance with your bills under the Tufts Medical Center Financial Assistance Program (the "Program"). We have reviewed your application and supporting documentation and have determined that, based on your income, you are not eligible for a discount under the Program.

We have determined that your income of \_\_\_\_\_ for your family size of \_\_\_\_\_ is more than the limit of \_\_\_\_\_.

If you disagree with this decision or have recently had a change in circumstances, we are happy to reconsider your application in light of any new information that you have to offer. If you have any questions, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone

**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

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800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Denial Letter—Incomplete Application]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

Thank you for your application for assistance with your bills under the Tufts Medical Center Financial Assistance Program that you filed on \_\_/\_\_/\_\_\_\_. As of today's date we have not received the necessary supporting documentation to process your application and, as such, are denying your application for assistance.

Once you have compiled the required supporting documentation, we encourage you to file a new financial assistance application for our consideration. If you have any questions, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone



**APPENDIX E: (FAP)—ELIGIBILITY NOTIFICATION LETTERS**

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School of Medicine*



800 Washington Street  
Boston, Massachusetts 02111  
T 617 636-5000  
[tuftsmedicalcenter.org](http://tuftsmedicalcenter.org)

*[Denial Letter—Services Not Eligible]*

Month Day, Year

name  
address  
city, state, zipcode

Patient account number:

Dear:

Thank you for your application for assistance with your bills under the Tufts Medical Center Financial Assistance Program (the "Program") that you filed on \_\_/\_\_/\_\_\_\_. We regret to inform you that the services you received on \_\_/\_\_/\_\_\_\_ are considered not medically necessary and as such are not eligible for financial assistance under the Program. Please remit your payment promptly to avoid additional collection actions.

If you disagree with this decision or have any questions, please contact the Financial Coordinator listed below.

Sincerely,

Name

Title, Telephone