Mass General Brigham

FINANCIAL ASSISTANCE PROGRAM

Financial Assistance Application Cover Page
Mass General Brigham

Massachusetts General Hospital	Massachusetts General Physicians Organization
Brigham and Women's Hospital	Brigham and Women's Physicians Organization
Salem Hospital	North Shore Physicians Group
Newton-Wellesley Hospital	Newton-Wellesley Medical Group
Brigham and Women's Faulkner Hospital	Martha's Vineyard Hospital
Mass Eye and Ear	Mass Eye and Ear Associates
Nantucket Cottage Hospital	Nantucket Cottage Medical Group
Cooley-Dickinson Hospital	Cooley-Dickinson Medical Group
Spaulding Rehabilitation	McLean Hospital
Wentworth-Douglass Hospital	Wentworth Health Associates

Dear Applicant:

You may be able to get financial help from Mass General Brigham Financial Assistance Program and possibly other healthcare organizations

How to Apply

To find out if you or your household qualifies, you must complete the application and provide proof of income, and copies of the following documents:

Documentation that is required to be submitted with your application	Included
1. Complete copy of your most recent Federal Income Tax Return (1040 Form) and all supporting schedules, including last year's W-2 form(s) OR if you do not file a tax return, please see the acknowledgement statement below ☐ **Acknowledgement Statement** By checking this box, I acknowledge and affirm that I have not filed federal or state income taxes for the most recent tax year. I understand that this declaration is made truthfully and voluntarily. Signature _____ Date Signed: _____	

2. Copies of the three (3) most recent, consecutive paycheck stubs, regardless of pay cycle, or a statement from the employer on company letterhead	
3. If Self-Employed, 12 months (from the current month) profit and loss statement is required; last year's tax return will not be considered	
4. If you do not have an income, see the No Income and Support Proclamation below, which we require to process your application. Please request the form	
5. Copies of three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.). All accounts and ALL PAGES ARE REQUIRED (including blank pages) *a. If you do not have a bank account(s), you will be asked to sign a No Bank Account Proclamation Form, which we require in order to process. Please request the form*	
6. Copies of unemployment or disability compensation benefits (include start date)	
7. Copies of pension benefits	
8. Copy of Social Security income (yearly benefit statements, copy of check or direct deposit)	
9. Copies of Government Assistance Notices, including Department of Health and Human Services Spend Down & a copy of the Food Stamp allocation, determination letter. *ALL PAGES ARE REQUIRED*	
10. Copy of Worker's Compensation (indicate date of injury). You must fully disclose any other coverage, third-party liability claim, motor vehicle coverage, or workers' compensation coverage to be considered.	
11. Copies of Child support agreement, proof of payment with payment frequency, or a letter indicating proof of payment support paid and/or received	
12. If you are married but have separated from your spouse, a copy of your legal separation document is required from the court b. ***If you did not go through the court system for your separation, you will be asked to provide notarized statements of separation and/or lease agreements***	
13. Do you have private Dental insurance? If yes, you do not meet the eligibility criteria for the WHP Community Dental Center. You should enroll with a private dental practice. *NH Medicaid, DentaQuest and MaineCare are accepted. All patients are expected to pay a $35 visit fee at the time of service. - Additional charges will apply for dentures, partials, and other laboratory services. *Massachusetts residents would not be eligible for dental services	
14. Additional qualification requirement specific to eligibility for services at WHP Community Dental Center: Live in primary service area - which includes: Barrington, Berwick, Dover, Durham, Lee, Madbury, Rollinsford, Somersworth, and South Berwick **OR** see a WHP PCP or Specialty Provider.	

****WE CAN MAKE <u>COPIES</u> FOR YOU OF ANY APPLICABLE DOCUMENTATION ****
Documents are NOT returned to applicants; they are scanned and securely destroyed.

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Please use this checklist to be sure we have all the information needed to quickly and correctly process your application. We may ask you for additional information, so please verify that the contact information you have listed is accurate.

Please note that most elective procedures will not be considered for assistance, such as;

- Cosmetic Surgery
- In-Vitro Fertilization (IVF)
- Advanced Reproductive Therapy (ART)
- Gastric Bypass Services absent of a payer's determination of medical necessity
- Accounts linked to a research study
- Patient Convenience items, inclusive of premium accommodations and overnight accommodations that are based on a patient request and typically not covered by a health insurance plan
- Other non-medically necessary services that are billed according to a pre-determined self-pay fee schedule
- All Residential All-Inclusive programs at Mclean Hospital that do not submit claims to health insurance companies

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 Mass General Brigham Financial Counselors can help

The information you provide is confidential.

You will continue to be financially responsible for any services you receive until we have learned whether you qualify for help. To prevent anything from going to collections, a payment plan may be set up with the Customer Service Dept at 617-726-3884.

To ensure prompt review of your application, please complete all sections unless otherwise indicated. The processing of the application will be delayed if you are missing required information or documentation.

If you have not heard from us within 30 days of returning your application, or if you need help understanding it, please call our Financial Assistance Office, and one of our representatives will assist you.

To view Mass General Brigham's Financial Assistance policy, click the link; Financial Assistance | Mass General Brigham

Applications can be mailed, emailed, or faxed:

Mass General Brigham patients;
Patient Billing Solutions
399 Revolution Drive, Suite 410
Somerville, Ma 02145-1462
Phone 617-726-3884, Fax 857-282-5642
Email address; PHSFinancialApplication@mgb.org

Wentworth-Douglass Hospital & Wentworth Health Partners Patients;
Mail to: 789 Central Avenue, Dover, NH 03820

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In Person: 121 Broadway, Dover, NH 03820
Phone 603-740-3234, Fax 603-740-3366
Email address; Charity.Care@WDHospital.org

FINANCIAL ASSISTANCE APPLICATION

1. Patient's Information:

Last Name	*First Name*	*Middle Initial*	*Social Security Number*	*Date of Birth*
Street Address	*City*	*State*	*Zip Code*	*Length of time at address*
Mailing Address	*City*	*State*	*Zip Code*	*Length of time at address*
Phone Number	*Email Address*	*Select applicable:*	❑ Single ❑ Married ❑ Civil Union ❑ Separated ❑ Divorced ❑ Widowed ❑ US Citizen ❑ NH Resident	

2. Person Responsible for Paying the Bill

Last Name	*First Name*	*Middle Initial*	*Relationship to Patient*	*Social Security Number*
Address if Different from Patient's		*Phone Number*	*Email Address*	
Name of Insurance Company (listed on year prior Tax Return)			*Effective Date*	

3. **Please indicate ALL people living in the household, including applicant: Use additional sheet of paper if needed.

NAME	*RELATIONSHIP TO PATIENT*	*DATE OF BIRTH*	*SOC. SECURITY #*	*DOCTOR'S NAME*
1.	**SELF**			
2.				
3.				
4.				
5.				
6.				

4. Is this for Dental services? ❑ Yes ❑ No

5.Please fill out if anyone in your household has insurance:

Health insurance (Plan/Name)_____ , Health savings account (check) - ❑ Yes ❑ No Who: _____

Policy #/ID# _____ Deductible Amount: _____

Medicare Part A_____, Medicare Part B_____ Receives assistance to pay Medicare Part B _____Who: Who? _____

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6. Has anyone in your household applied for Medicaid? ❑ Yes ❑ No

Who: _____ If Yes and denied please provide copy of the Medicaid denial notice.

7. Have you applied for financial assistance at another facility? ❑ Yes ❑ No If yes, where _____

8. Is anyone in your household pregnant? ❑ Yes ❑ No

9. Has anyone in your household served in the military? ❑ Yes ❑ No Who?_____

10. Have you recently filed a workers' compensation or motor vehicle accident claim? ❑ Yes ❑ No Date:_____

11. Is anyone in your household eligible for Social Security benefits? ❑ Yes ❑ No Who?_____

12. Does anyone else claim you on their income tax return? ❑ Yes ❑ No Who?_____

13. HOUSEHOLD INFORMATION	**PERSON 1 (Patient)**	**PERSON 2 (Spouse/Dependant)**	**PERSON 3 (Dependant)**
NAME of each household member:			
Name of employer:			
Monthly Income From:			
Employment:	$	$	$
Self-Employment:	$	$	$
Investment Accounts:	$	$	$
Real Estate Rentals:	$	$	$
Unemployment since _____ (Date)	$	$	$
Retirement: (Soc. security, Pension, Annuity)	$	$	$
Alimony/Child Support:	$	$	$
Public Assistance, Food Stamps:	$	$	$
Other Income:	$	$	$
Savings and Investments:			
Checking Account Balances:	$	$	$
Savings & CD Account Balances:	$	$	$
IRAs, 403B, 401K: Specify: _____	$	$	$
Other Savings and Investments: Specify: _____	$	$	$
Other:			
Automobile: Year, Make, Model?			
Recreational Vehicle: Year, Make, Model?			

14. HOUSEHOLD EXPENSES

Monthly Rent Payment: $_____ or Mortgage Payment: $ _____ Mortgage Loan Balance: $ _____

Property Tax Amount Not Included in Payment Amount Above: $ _____ Value of Home: $ _____

Do You Own Property Other Than Primary Residence? ❑ Yes ❑ No If Yes, Value?$_____ Mortgage balance:$_____

If other property is a business, list address: _____

Monthly Loan Payment: $ _____ Paid to: _____ For: _____

Medicare Part D deducted from Social Security check: ❑ Yes ❑ No Amount: $_____

Utilities	$ _____	Insurance (Auto/Life/Property)	$ _____	Other: _____	$ _____
Alimony/Child Support	$ _____	Health Insurance	$ _____	Other: _____	$ _____
Child Care	$ _____	Healthcare Bills	$ _____	Other: _____	$ _____
Living (gas, food, clothes)	$ _____	Medications	$ _____	Other: _____	$ _____

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15. ASSIGNMENT OF RIGHTS - *Read Carefully*

In the event that I have not fully disclosed, or have inaccurately represented, any income or assets, any agreement to provide you with a charitable care discount would be null and void and would be retroactive back to the date the bills were owed.

All adult household members who sign below authorize the release of any medical, financial, or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures may not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit, or any other payment.

If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income, and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

Applicant Signature Date

Co-Applicant Signature Date

Dependent Signature Date