

Dear Patient,

Attached is the BIDMC Financial Assistance Application. Please fill out in its entirety and return with all required documentation. Incomplete applications may result in denial of financial assistance.

The deadline to return the application is 240 days from the first billing statement for the services which financial assistance is being requested.

Beth Israel Deaconess Medical Center and its affiliates are dedicated to providing financial assistance to patients who have healthcare needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay for medically necessary care based their individual financial situation.

If you have questions please contact Financial Counseling at the number listed below.

Thank you.

Return Application to:

Financial Counseling Unit  
Beth Israel Deaconess Medical Center  
East Campus/Rabb  
Room 111  
330 Brookline Avenue  
Boston, MA 02215  
617-667-5661

# Application for Financial Assistance

**Please Print**

Today's Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street
Apt. Number

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City
State
Zip Code

Date of Hospital Services: \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

Did the patient have health insurance or Medicaid\*\* at the time of hospital service? Yes  No   
 If "Yes", attach a copy of the insurance card (front and back) and complete the following:

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

\*\*Prior to applying for financial assistance, you must have applied for Medicaid in the past 6 months and will need to show proof of denial.

*Note: Financial assistance may not apply if a Health Savings Account (HSA), Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or similar fund designated for family medical expenses has been established. Payment from any established fund is due before assistance can be provided.*

**To apply for financial assistance complete the following:**

List all family members including the patient, parents, children and/or siblings, natural or adopted, under the age 18 living at home.

Family Member	Age	Relationship to Patient	Source of Income or Employer Name	Monthly Gross Income
1.				
2.				
3.				
4.				

In addition to the Financial Assistance Application we also need the following documentation attached to this application:

- Current state or federal income tax returns
- Current W2
- Four most recent payroll stubs
- Four most recent checking and/or savings account statements

If these are not available, please call the Financial Counseling Unit at (617) 667-5661 to discuss other documentation they may provide.

By my signature below, I certify that I have carefully read the Financial Assistance Policy and Application and that everything I have stated or any documentation I have attached is true and correct to the best of my knowledge. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

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

Relationship to Patient: \_\_\_\_\_

Date Completed: \_\_\_\_\_

If your income is supplemented in any way or you reported \$0.00 income on this application, have the Support Statement below completed by the person(s) providing help to you and your family.

**Support Statement**

I have been identified by the patient/responsible party as providing financial support. Below is a list of services and support that I provide.

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I hereby certify and verify that all of the information given is true and correct to the best of my knowledge. I understand that my signature will not make me financially responsible for the patient's medical expenses.

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Please allow 30 days from the date the completed application is received for eligibility determination. If eligible, financial assistance is granted for six months from the date of approval and is valid for all Beth Israel Deaconess affiliates:

- Beth Israel Deaconess Medical Center-Boston
- Beth Israel Deaconess Milton
- Beth Israel Deaconess Needham
- Beth Israel Deaconess Plymouth

Staff Only.
Application Received by:
BIDMC <input type="checkbox"/>
BID Milton <input type="checkbox"/>
BID Needham <input type="checkbox"/>
BID Plymouth <input type="checkbox"/>
Date Received: