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

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.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>Relationship to Patient</th>
<th>Source of Income or Employer Name</th>
<th>Monthly Gross Income</th>
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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.

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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 ☐
BID Milton ☐
BID Needham ☐
BID Plymouth ☐
Date Received: