PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

Partners HealthCare Financial Assistance Application

Please print out and complete all sections of the application that apply to you. This application cannot be completed electronically. Please read all instructions before completing application.

This application is used to evaluate your eligibility for financial assistance on medical bills from Partners HealthCare providers. You can use this application to apply for help with health care bills from any of the following Partners HealthCare entities:

Massachusetts General Hospital	Massachusetts General Physicians Organization
Brigham & Women's Hospital	Brigham & Women's Physicians Organization
North Shore Medical Center	North Shore Physicians Group
Newton-Wellesley Hospital	Newton-Wellesley Medical Group
Brigham & Women's Faulkner Hospital	Martha's Vineyard Hospital
Nantucket Cottage Hospital	Nantucket Cottage Medical Group
Cooley-Dickenson Hospital	Cooley-Dickenson Medical Group
Spaulding Rehabilitation Network	McLean Hospital

Partners Financial Assistance is not considered a substitute for enrolling in any available health insurance program. Discounts are limited based on the type of services provided and the location that the care was provided.

- Emergency Services and Urgent Services will generally be considered for discounts.
- In most cases, Elective Services, Post-Acute Care Services and Behavioral Health Services (nonemergency) are excluded from a Financial Assistance Discount. Elective Services, Post-Acute Care Services and Behavioral Health Services are typically screened for financial clearance prior to service delivery and may be deferred based on the patient's overall medical status after a review with the appropriate providers.
- Other Services are always excluded from Financial Assistance Discounts.
- Discounts on insurance co-payments, co-insurance or deductibles are generally excluded

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 PHS Financial Counselors can help.

You must fully disclose any other coverage, third-party liability claim, motor vehicle coverage or workers compensation coverage to be considered.

If you have any questions on this application, please contact Patient Financial Services at your hospital or call (617) 726-3884.

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Application checklist

- ❑ Complete all applicable sections of the application- a section will indicate if it can be left blank.

- ❑ Include a copy of your driver's license, other photo identification or documents that verify your current residence. Anything submitted must include your name (Section 1).

- ❑ Include some form of income verification (Section 3 and Section 4).
  - Include a copy of your most recent IRS 1040 or 1040A
  - If there has been a recent change in your income, include documentation such as recent check stubs (minimum 4), unemployment statements, bank/investment statements and/or social security statements.

- ❑ If your family is over 300% of the current US Federal Income Poverty Guidelines (FPL) you must also complete Section 5. You are over 300% FPL if your income is over the following limits:

Family Size	1	2	3	4	5
2019 FPL	$37,476	$50,736	$63,996	$77,256	$90,516

- ❑ Assets may be used to determine your potential to pay your medical bills. You will need to provide information on your assets if any of the following apply to you (Section 6):
  - Your permanent residence is outside of the United States
  - You are requesting a discount for a service that is generally ineligible (e.g. non-emergency related care, co-payments, co-insurance and deductibles)
  - You are requesting a discount at McLean Hospital, Partners HealthCare at Home or a Spaulding Network facility.

- ❑ Return completed applications directly to one of the PHS Patient Financial Counselors OR mail to:

Partners HealthCare
Patient Billing Solutions
399 Revolution Drive, Suite 410
Somerville, MA 02145-1462

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.

Partners HealthCare Financial Assistance Application

1. Basic Information

Please complete this section about the applicant. The applicant is either the patient or the person who is financially responsible for the patient.

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 your name.

Last name	**First name**	**MI**

Date of birth	**Gender** Male ❑ Female ❑
Telephone numbers Home: ( ) Work: ( ) Cell: ( )	**Mailing address** (include city, state and zip code)

Patient's name *(if different from applicant)*	**Patient's dates of service (include location where the services were provided)**
Patient's date of birth *(if different from applicant)*	
Patient's Medical Record Number (MRN) and Account Number (statement)	

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2. FAMILY INFORMATION

If applicable, please list the applicant's spouse and children under 19 who live with the applicant. This section can be left blank if the applicant does not live with a spouse or children.

Name of family member	Relationship	Date of birth

3. EARNED INCOME

Please complete this section about earned income for applicant and each household member listed in Section 2 who works. **Please list gross income, which is income before taxes and deductions.** This section can be left blank if the applicant and his/her household members do not have any earned income.

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

Name of working family member	Employer name and address	Gross amount earned	How often *check one*	Facility use only
			☐ Weekly ☐ Monthly ☐ Yearly	
			☐ Weekly ☐ Monthly ☐ Yearly	
			☐ Weekly ☐ Monthly ☐ Yearly	
			☐ Weekly ☐ Monthly ☐ Yearly	

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4. OTHER INCOME

Please complete this section about other income for the applicant and each household member listed in Section 2 who receives other income. Other income is money you receive that does not come from an employer. **Please list gross income, which is income before taxes and deductions.** This section can be left blank if the applicant and his/her household members do not have any other income.

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

Type of income	Family member(s) receiving income	Gross amount received	How often *circle one*	Facility use only
Unemployment			Weekly, Monthly, Yearly	
Social Security			Weekly, Monthly, Yearly	
Veteran's Benefits			Weekly, Monthly, Yearly	
Annuities and Pensions			Weekly, Monthly, Yearly	
Child Support & Alimony			Weekly, Monthly, Yearly	
Rental Income			Weekly, Monthly, Yearly	
Workers Compensation			Weekly, Monthly, Yearly	
Dividend & Interest Income			Weekly, Monthly, Yearly	
Other			Weekly, Monthly, Yearly	

5. OTHER HEALTH CARE EXPENSES

This section may not be applicable to you. Please complete this section only if your family income is more than 300% of the Federal Income Poverty Guidelines (as outlined on page 2).

If you are over 300% the Federal Income Poverty Guidelines, you need to list health care expenses from locations not listed on page 1 (i.e. non-Partners HealthCare facilities). This section can be left blank if your family income is less than 300% or if you do not have health care expenses from facilities outside of Partners HealthCare. Documentation may be requested but is not required at this time.

Medical expenses	Total Amount	How often does the cost occur?	Facility use only *Total Cost*
Medical Bills		Weekly, Monthly, Yearly	
Pharmacy Bills		Weekly, Monthly, Yearly	

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6. ASSET INFORMATION

This section may not be applicable to you. Please complete this section only IF:

- Your permanent residence is outside of the United States **OR**
- You are requesting a discount for non-emergency related care, co-payments, co-insurance or deductibles. Patients requesting financial assistance for non-emergency related care provided at a Spaulding Network entity or McLean Hospital do not need to provide asset information.

This section can be left blank if you do not fit into any of the categories listed above.

DOCUMENTATION REQUIRED: Please include documentation that verifies this income: bank statements or other proof.

You do not need to include your primary residence (where you live)

Asset	Owner(s)	Bank or company name	Cash value
Savings Accounts			
Checking Accounts			
Credit Union Accounts			
Trust Funds			
Stocks/Bonds			
Money Market Accounts			
Mutual Funds			
Commercial or investment property			
Other			

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7. AUTHORIZATION

Please read this section carefully and sign at the bottom.

All information in this application is true to the best of my knowledge. I agree to provide additional documentation upon request. **I understand that this confidential information cannot be disclosed to any party outside of Partners HealthCare System, Inc. without my prior approval.**

_____ _____

Signature of applicant Date

If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.

_____ _____

Signature of authorized representative Date

_____ _____

Name of authorized representative Relationship to applicant

Contact phone number _____

Before submitting, please make sure that you have completed all applicable sections of this application and have included all requested documents to verify your financial status. Incomplete applications will not be approved.