Financial Assistance Program
Northeast Hospital Corporation

Policy Effective Date: October 1, 2016

We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels. Incomplete forms will not be processed. Income verification such as previous Income Tax Return or check stubs need be included for this form to be considered complete.

NHC MRN: _____

1) **Patient Information**

Patient Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Telephone # _____ Social Security # _____

Date of Birth ____/___/_____ Marital Status _____ Occupation _____

2) **Family Information**

List all persons living in home and legally **dependent** upon your support (as claimed on your income tax return)

Full Name	Relationship	DOB	Occupation
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

3) **Family Income**

Employer (Applicant) _____ Employer (Spouse) _____

Combines Household Monthly Income $ _____
(Include all taxable income, wages, salary, tips, etc.)

Child Support $_____ SS Benefits $ _____
Unemployment $_____ Disability $ _____
Veterans Benefits $_____ Pension Benefits $ _____
Workers Compensation $ _____ Rental Income $ _____

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4) **Assets**

Checking Account Balance $_____ Retirement Fund $ _____
Savings Account Balance $_____ Stocks/Bonds $ _____
Certificates of Deposit $_____ Credit Union $ _____
Money Market $_____ Other $ _____

5) **Housing Expense**

(Circle One) Rent / Own Monthy Payment Amount $ _____
Auto: Year Make
_____ _____ Monthly Payment Amount $ _____
Support Payments: Type _____ Amount $ _____
(Any support payments ordered by the court and made by the applicant or spouse)

6) **Other Financial Assistance Programs**

Please indicate other financial assistance programs applied for within the last year and current status:

Social Security Disability Approved / Denied Denial Reason: _____
Home State Medicaid Approved / Denied Denial Reason: _____
Out of State Medicaid Approved / Denied State ____ Denial Reason _____
(Copy of Approval or Denial Letter Required)

Please Read the Following and Sign Below:

I certify that the information provided in this application is true to the best of my knowledge. I authorize NHC to investigate the information I have provided in this application for purposes of financial assistance eligibility. If a resident of Massachusetts, I agree to complete an application through the MassHealth Program. I agree to provide documentation as requested by the Mass Health Program and NHC. I agree to provide NHC with changes to household income, members and health insurance. I will notify NHC if services provided are to be paid by my employer, auto insurance or other responsible party. I understand that this financial assistance program is a payer of last resort.

_____ _____ _____
Name of Applicant Signature of Applicant Date

Please return completed application including **required documentation** to:

Northeast Hospital Corporation
NHCFAP - Patient Financial Services
41 Mall Road
Burlington, MA 01805

Please call if you have any questions:

(781) 744-5800 Local

(866) 366-5800 Out of Area
Monday - Friday 8:00 AM - 5:00 PM

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Documentation Required

Income Verification Required, if applicable:

1. Copies of you most recent 1040 or 1040-EZ Federal Tax Return. The copy must include all schedules and forms that were submitted with your return.
2. Copies of the last **two** recent paycheck stubs for each employed household member.
3. Self-Employed applicants must provide an up-to-date Profit & Loss Statement.
4. Copy of child support and/or alimony statement.
5. Copy of unemployment benefit statement or check stubs.
6. Copy of veterans benefit statement or check stubs.
7. Copy of workers compensation benefit statement or check stubs.
8. Current annual social security, pension, or SSI Statement.
9. Short-term or long-term disability benefit statement or check stubs.
10. Statement of Rental Income.

*** Copy of bank statement is acceptable, if any of the above identified above are direct deposit.