UMASS MEMORIAL HEALTH CARE

FINANCIAL ASSISTANCE PROGRAM APPLICATION

☐ UMass Memorial Medical Center ☐ UMass Memorial HealthAlliance-Clinton Hospital ☐ UMass Memorial - Marlborough Hospital
☐ UMass Memorial Medical Group - Location: _____

1. Patient Information

Print your full name, address and contact information for the person requesting assistance.

Name: _____
Last First Middle Initial

Address: _____ City: _____ County: _____
Number and Street

State: _____ Zip Code: _____ SSN: _____ /_____ /_____ Date of Birth: _____ /_____ / _____

Marital Status: ☐ Single ☐ Married ☐ Divorced Home Phone: (_____) _____ Other Phone: (_____) _____

2. Family Members

List all family members in your household.

Please provide the following information for all of the people in your immediate family who live in your home. Family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

	Name of Family Members	Date of Birth	Relationship	Social Security Number (SSN)
1.				
2.				
3.				
4.				
5.				
6.				

3. Wages

Please provide documentation of all wages listed.

Family Member	Amount	How Often Received?
1.		
2.		
3.		
4.		
5.		
6.		

4. Other Income
Please provide documentation of all income listed.

Type of Income	Household Member Receiving Benefit	Amount	How Often Received? (circle one)
Social Security		$	Weekly, Monthly, Annually
Unemployment		$	Weekly, Monthly, Annually
Pension		$	Weekly, Monthly, Annually
Disability Funds		$	Weekly, Monthly, Annually
Veteran's Benefits		$	Weekly, Monthly, Annually
Child Support		$	Weekly, Monthly, Annually
Alimony		$	Weekly, Monthly, Annually
Worker's Comp		$	Weekly, Monthly, Annually
Net Rental Income		$	Weekly, Monthly, Annually
Self-Employment Income		$	Weekly, Monthly, Annually
Trust Income		$	Weekly, Monthly, Annually
Other		$	Weekly, Monthly, Annually

5. Comments / Affidavit of Support
Use this section for additional information or your statement of support.

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs:

_____

_____

_____

_____

_____

6. Health Insurance Information
Please provide information on Health Insurance Coverage.

Did you have health insurance at the time of your service? ☐ No ☐ Yes

If yes, please provide your insurance information and a copy of your insurance card:

_____

Insurance Company Name ID Number Subscriber Name Effective Date

By signing below, I certify that everything I have stated on this application and on any attachments is true to the best of my knowledge.

I agree to provide additional documentation upon request to determine my eligibility.
I am aware that falsification of any information may result in a denial of financial assistance.

I agree to tell the hospital of any change in my income, family size, health insurance coverage, or other information that may change my eligibility for financial assistance.

_____ _____ _____ _____
Applicant/Guarantor Signature Printed Name Date Time

_____ _____ _____ _____
Authorized Representative Signature Printed Name Date Time