MelroseWakefield Healthcare
Proudly wellforce

MelroseWakefield Hospital
Lawrence Memorial Hospital of Medford

Financial Assistance Application

MelroseWakefield Healthcare takes pride in providing the best care for every patient. MelroseWakefield Healthcare offers financial assistance through its financial assistance policy to patients unable to pay for emergency or medically necessary care. MelroseWakefield Healthcare financial assistance is not intended to cover non-emergency, non-urgent related care. It is not intended to provide discounts on insurance co-payments, co-insurance, or deductibles.

Patients who have the means are expected to pay for services received at MelroseWakefield Healthcare. However, eligibility for financial assistance is available to you. Patients are strongly encouraged to apply for any available government assistance programs, like MassHealth, or Health Safety Net, before applying to the MelroseWakefield Healthcare financial assistance program. 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 MelroseWakefield Healthcare financial counselors can help.

Your qualification for financial assistance programs is dependent upon your full and accurate completion of this financial assistance application.

Application Instructions

Please fully complete the financial assistance application and include copies of the following documents for all applicants. Failure to return all necessary documents within 30 days will cause the application to be denied. Please attach copies of any documents submitted as unfortunately they cannot be returned.

- ☐ Complete all applicable sections of the application and be sure to sign the affidavit statement on page 4.
- ☐ Include a copy of your driver's license, other photo identification, or documents that verify your current residence. Anything submitted must include your name and current address.
- ☐ Include a copy of your insurance card(s).
- ☐ Include some form of income verification:
  - ☐ Include a copy of your most recent W2(s) or pay stubs (4 if paid weekly, 2 if paid bi-weekly)
  - ☐ If there has been a recent change in income, include documentation such as unemployment statements, bank/investment statements, long-term care statements, pension statements, and/or social security statements.
- ☐ If patient is deceased, please provide a copy of the death certificate and a letter stating the status of the estate.

Financial Counselors:

For assistance in completing your application, please contact us at **781-338-7111** to schedule an appointment with one of MelroseWakefield Healthcare's financial counselors**.** The financial counselors are located at: MelroseWakefield Hospital, 585 Lebanon Street, on the 1st Floor near the Porter Street entrance in Melrose or Lawrence Memorial Hospital, 170 Governors Avenue, near the emergency department in Medford.

Please Send Your Completed Application to:

MelroseWakefield Healthcare
Financial Counselors
170 Governors Avenue
Medford, MA 02155

Exhibit D

MelroseWakefield Healthcare
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Part I: About the Patient		
Patient Name:		
Patient Date of birth:	Patient SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Are you a citizen of the United States? ☐ YES ☐ NO		
If NO, are you a permanent resident, legally residing in the United States? ☐ YES ☐ NO		

Applicant Information (if different than Patient Information above)		
The applicant is either the patient or the **person who is financially responsible for** the patient.		
Applicant Name:		
Applicant current address:		
City:	State:	ZIP Code:
Applicant Phone:		

About Patient Household	
List all household members, their date of birth and relationship to the applicant. A household member is a person who is related to you or lives with you for the entire year as a member of your household that you claim on your income tax return.	
Household Member 1:	
Date of Birth:	Relationship to Patient:
Household Member 2:	
Date of Birth:	Relationship to Patient:
Household Member 3:	
Date of Birth:	Relationship to Patient:
Household Member 4:	
Date of Birth:	Relationship to Patient:
Household Member 5:	
Date of Birth:	Relationship to Patient:

Part 2: Patient Insurance Information	
❒YES ❒NO	Have you submitted a Medicaid application within the last six (6) months?
❒YES ❒NO	Do you have a pending or approved Medicaid application?
❒YES ❒NO	Has your Medicaid application been denied?
❒YES ❒NO	Do you have medical insurance?
Primary Insurance Information:	
Insurance Name:	
Insurance Address:	
Policy/ID #::	Group #:
Subscriber Name::	
Subscriber Date of Birth:	Relationship to Subscriber:
Subscriber Employer:	Effective Date:
Secondary Insurance Information	
Insurance Name:	
Insurance Address:	
Policy/ID #:	Group #:
Subscriber:	Subscriber Date of Birth:
Relationship to Subscriber:	Subscriber Employer:
Effective Date:	

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Part 3: Monthly Gross Income and Assets

Please complete this part about earned income and assets for patient and each household member listed in Section 1 who works. Please list gross income, which is income before taxes and deductions.

	Patient	Household Member 1	Household Member 2	Household Member 3	Household Member 4	Household Member 5
Wages/Salary/Tips						
Unemployment Compensation						
Social Security						
Child Support + Alimony						
Self-Employment Income, after Expenses						
Interest/Dividend Income						
Pension						
IRA/Stocks/Bonds						
Rental Income						
Trust Payments						
Workers Compensation						
Veteran Benefits						

Lack of Income Statement

☐ YES ☐ NO If the household income is zero, is there anyone supporting you?.

If you answered yes above, and you are being financially supported by another person, please have them complete and sign the statement below.

Patient Name:_____, currently has no income. I am currently supporting them with food, shelter, and any clothing needed. I also give them financial help in the amount of $_____ on average per month.

Support Giver Signature:_____Date: _____

Household Assets

List any checking or saving account information below.

Type of Account	Bank Institution	Balance as of _____

Other Household Countable Assets

List information you have for any of the following types of accounts.

Type of Account	Bank Institution	Balance as of _____
Stocks/Bonds		
Certificate of Deposit		
US Savings Bonds		
Health Savings Account		
Savings Certificate		
Christmas or Vacation Clubs		
Other		

Part 4: Medical Hardship

This section may not be applicable to you. Please complete this section if you have significant medical bills. List all healthcare expenses from MelroseWakefield Healthcare and other providers. Documentation may be requested but is not required at this time.

Provider Name	Total Medical Expenses	How Often Does the Cost Occur?
		❒Weekly ❒Monthly ❒Yearly
		❒Weekly ❒Monthly ❒Yearly
		❒Weekly ❒Monthly ❒Yearly
		❒Weekly ❒Monthly ❒Yearly
		❒Weekly ❒Monthly ❒Yearly
		❒Weekly ❒Monthly ❒Yearly

Part 5: AFFIDAVIT – ALL APPLICANTS MUST SIGN

All applicants **MUST** sign the affidavit below for their application to be considered.

I swear and affirm that all the information indicated on this form is true, correct, and complete to the best of my ability and knowledge and belief. I agree to report to MelroseWakefield Healthcare any and all changes in income, financial resources or other information indicated on this form which may affect my eligibility to receive financial assistance at MelroseWakefield Healthcare. I understand that my credit and other financial information may be referenced to verify my statement and eligibility for the program. I understand that I have thirty (30) days to submit accurate and necessary supporting documentation to be considered for a discount.

Fraudulent statements by the patient for the purpose of obtaining financial assistance will be forwarded to the Massachusetts Attorney General's Office. Patients who falsify the Program application will no longer be eligible for the Program and will be held responsible for all charges incurred while enrolled in the Program retroactively to the first day that charges were incurred under the Program.

Applicant's Signature:_____ Date: _____

AFFIDAVIT – ONLY APPLICABLE IF APPLICANT'S SPOUSE IS APPLYING

If applicant's spouse is also applying for financial assistance, applicant's spouse **MUST** sign the affidavit below for their application to be considered.

I swear and affirm that all the information indicated on this form is true, correct, and complete to the best of my ability and knowledge and belief. I agree to report to MelroseWakefield Healthcare any and all changes in income, financial resources or other information indicated on this form which may affect my eligibility to receive financial assistance at MelroseWakefield Healthcare. I understand that my credit and other financial information may be referenced to verify my statement and eligibility for the program. I understand that I have thirty (30) days to submit accurate and necessary supporting documentation to be considered for a discount.

Fraudulent statements by the patient for the purpose of obtaining financial assistance will be forwarded to the Massachusetts Attorney General's Office. Patients who falsify the Program application will no longer be eligible for the Program and will be held responsible for all charges incurred while enrolled in the Program retroactively to the first day that charges were incurred under the Program.

Applicant's Spouse Signature:_____ Date: _____