

Financial Assistance Policy

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I. Purpose

MelroseWakefield Healthcare, commonly referred to as “Hospital” throughout this policy, is committed to providing quality healthcare services to the community. The Hospital provides medically necessary services to all patients regardless of their ability to pay. The Hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, disability, substance abuse, socio-economic status, lack of insurance, or physical appearance in providing its services. In order to provide such high quality services and support the needs of its community, MelroseWakefield Healthcare must maintain a viable financial foundation that includes the timely collection of its accounts receivable.

MelroseWakefield Healthcare recognizes that some patients have limited means and may not have access to insurance coverage for all services. This policy has been developed to inform uninsured and underinsured patients with limited financial resources of the various Hospital financial assistance programs that might be available to them.

Patients who have the means are expected to pay for services provided by MelroseWakefield Healthcare. This policy assumes that patients who have access to affordable insurance will apply for and maintain their coverage. MelroseWakefield Healthcare financial assistance programs are intended to primarily serve patients who do not have health insurance from either a public (e.g., Medicare or Medicaid) or private (e.g., Blue Cross Blue Shield, Harvard Pilgrim, etc.) source and have an unmet financial need. If applicable criteria are met, MelroseWakefield Healthcare discounts may be available to patients with demonstrated financial need either due to limited income or if their medical bills are an excessive portion of their income.

II. Definitions

Emergency Services: medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395dd(e)(1)(B). A medical screening examination and any stabilizing treatment for an emergency medical condition, including but not limited to inpatient medical care or any other such service rendered to the extent required under the Emergency Medical Treatment and Labor Act (EMTALA) (42 U.S.C. § 1395(dd)), qualifies as Emergency Services.

Urgent Services: medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing the patient’s health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual’s health.

Medically Necessary Non-Emergency, Non-Urgent Services: services that do not meet the definition of Emergency or Urgent services but that are medically necessary. The patient typically, but not exclusively, schedules these services in advance.

Non-Medically Necessary Services: a procedure, test, or service that does not impact the quality of health or require emergency or urgent care to be rendered.

III. General Provisions

- a. Participating Entities
This policy applies to services delivered and billed by the Hospital at the locations set forth in Appendix A- MelroseWakefield Healthcare Locations, Participating Entities. This policy does not apply to services delivered and billed by the entities listed in Appendix B- MelroseWakefield Healthcare Provider Affiliate List, Non-Participating Entities even in the case where such services may be rendered in the Hospital locations set forth in Appendix A.
- b. MelroseWakefield Healthcare Uninsured and Underinsured Patients are defined as:
 - i. Patients with no health insurance (“uninsured”);
 - ii. Patients whose only “insurance” is the Massachusetts Health Safety Net;
 - iii. Patients who have balances resulting from having “exhausted” benefits under their insurance plan; or
 - iv. Patients whose balance results from “non-covered” services where insurance has determined that the patient is fully responsible for the charges associated with the excluded services. This includes services where the insurer denied coverage due to the insurer’s network limitation.
- c. Patient Responsibilities:
 - i. The patient has a number of responsibilities to meet in order to qualify for assistance from the Hospital under this policy, including:
 1. Obligation to obtain and maintain insurance coverage, if affordable coverage is available to them;
 2. Obligation to apply for any government-sponsored insurance program they may qualify for;
 3. Obligation to submit, in a timely manner, all requested documentation of income, assets, identity, and residency that is required to enroll in State coverage and/or to complete the MelroseWakefield Healthcare financial assistance application;
 4. Obligation to keep the Hospital apprised of current demographic and insurance information; and
 5. Obligation to pay all balances in accordance with agreed upon time frames.
- d. MelroseWakefield Healthcare Financial Assistance and Counseling:
 - i. Insurance Coordinators proactively review identifiable uninsured and underinsured patients scheduled for service and coordinate with patients and MelroseWakefield Healthcare Financial Counselors to schedule appointments to discuss financial assistance options.
 - ii. Patients are also referred to Financial Counselors from MelroseWakefield Healthcare departments.
 - iii. Financial Counselors screen patients for eligibility for public and/or private insurance coverage.
 1. MelroseWakefield Healthcare screens patients for eligible state and federal programs. In order to be eligible for discounts under this policy, patients may be required to apply for a variety of state and federal programs, including but not limited to MassHealth and/or Medicare.
 2. If the patient meets public eligibility guidelines, Financial Counselors will advise on the application process and assist the patient with the application when possible.
 3. If the patient does not meet public eligibility guidelines (i.e., based on their Federal Poverty Level (“FPL”), immigration status, etc.), is denied for any available public programs, or if the public program will not fully cover the patient’s costs, Financial Counselors will advise of private coverage options and screen the patient for eligibility under MelroseWakefield Healthcare’s Financial Assistance Discount Program (Section IV below).

IV. MelroseWakefield Healthcare Patient Discount Programs

- a. MelroseWakefield Healthcare offers the following patient discount programs:
 - i. Low Income Patient Discount, as qualified by MelroseWakefield Healthcare FPL thresholds (Section IV(g)).
 - ii. Medical Hardship Discount, as qualified by MelroseWakefield Healthcare thresholds (Section IV(h)).
 - iii. Uninsured and Underinsured Discount (Section IV(i)).

Discounts under these programs may be granted to all balance(s) of gross charges with a patient responsibility that meet MelroseWakefield Healthcare determined thresholds in Appendix C - MelroseWakefield Healthcare financial assistance discount amounts, excluding patient co- payments, deductibles, and co-insurance. If patients qualify for multiple discount programs, the program with the highest discount will be given.

Discounts will not be based upon any relationship that the patient or his/her family may have with any Hospital employee or member of the governing body. Discounts will not be extended based upon any consideration of “professional courtesy” for a clinician or his/her family. Discounts will not be offered to patients to induce the patient to receive services or otherwise be linked in any manner to the generation of business payable by a federal healthcare program nor will they be redeemable for cash for items or services provided by the Hospital, or any other MelroseWakefield Healthcare entity (this includes discounts to the gift shop, cafeteria, etc.).

- b. Application and Screening Process
 - i. Patients must submit a completed MelroseWakefield Healthcare Financial Assistance Application (Appendix D) along with the necessary supporting documentation in order to be considered for assistance. Necessary documentation may include, but is not limited to proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), (4) assets of those individuals who are 65 and over, and (5) insurance information, including benefit coverage and network limitations. All supporting documentation must be submitted within 30 days of the initial submission of the application in order for the application to be considered by the Hospital.
 - ii. Confidential applications may be submitted to the Hospital for minors and abused individuals. Such individuals should contact Financial Counselors.
 - iii. MelroseWakefield Healthcare does not take prior determinations of eligibility for MelroseWakefield Healthcare financial assistance into account in making its determination on a patient’s Financial Assistance Application.
 - iv. MelroseWakefield Healthcare reserves the right to re-verify eligibility for discounts every six months.
- c. Approval for Coverage:
 - i. The Hospital will notify patients in writing of MelroseWakefield Healthcare’s program eligibility determinations. Reference Appendix E- MelroseWakefield Healthcare Program Eligibility Determination Notifications.
 - ii. The Hospital reserves the right to deny applications if all supporting documentation is not timely received.
 - iii. Appeals of program eligibility determinations may be reconsidered if an applicant provides the Hospital with new information.
 - iv. The Department of Patient Accounts will be responsible for determining that the Hospital has made reasonable efforts to determine whether an individual is eligible for financial assistance.
- d. Patient Income Limitations:

- i. For residents of the United States, the most recently published FPLs for the total income of the family will be used as the primary determinant for the discounts described in [Section IV\(g\)](#) and [Section IV\(h\)](#).
 - ii. Non-US residents and US residents who meet the requirements of [Section III\(c\)](#) of this policy but who do not meet FPL qualifying criteria may be entitled to the Uninsured and Underinsured Discount as described in [Section IV\(i\)](#) below.
 - iii. All patients who meet the requirements of [Section III\(c\)](#) of this policy may qualify for a MelroseWakefield Healthcare Medical Hardship Discount as outlined in [Section IV\(h\)](#) below.
- e. Eligible Services:
- i. This policy is generally limited to medically necessary services provided and billed by MelroseWakefield Healthcare including:
 1. Emergency Services;
 2. Urgent Services; and
 3. Non-Emergency, Non-Urgent Services.
- f. Exclusions:
- i. MelroseWakefield Healthcare does not provide financial assistance for Non-Medically Necessary Services as such services are determined by the treating clinician. Examples of services that are ineligible for financial assistance from the Hospital include but are not limited to: nonmedical services (e.g., social, educational, or vocational, cosmetic surgery, research or other). The determination of which services are considered eligible for purposes of this policy resides solely with the Hospital.
 - ii. MelroseWakefield Healthcare does not generally provide discounts to patients for Non-Emergency, Non-Urgent services where the need for the care was anticipated by the patient and the patient came to MelroseWakefield Healthcare from outside its service area to receive care when the services are offered within the patient's service area.
 - iii. Patient co-payments, deductibles, and co-insurance are excluded from coverage under this policy.
- g. MelroseWakefield Healthcare Low Income Patient Discount:
- i. For residents of the United States, the most recently published FPLs for the total income of the family will be used as the primary determinant. Discounts based solely on income are generally limited to patients with family income levels less than 301% of the FPL.
 - ii. Patients who meet this threshold will be offered a discount at or greater than the Amount Generally Billed (AGB) rate as outlined in [Section IV\(j\)](#) below.
 - iii. The determination for this discount is the responsibility of MelroseWakefield Healthcare.
 - iv. Reference [Appendix C](#) and [Appendix D](#) for additional detail.
- h. MelroseWakefield Healthcare Medical Hardship Discount:
- i. Patients who do not meet the FPL thresholds requirements necessary to qualify for the MelroseWakefield Healthcare low income patient discount may still qualify for a discount if they can demonstrate that their medical expenses exceed 20% of their family income. Expenses must have occurred within the prior 12 months and are limited to those expenses that could potentially qualify as a medical expense under the Internal Revenue Service regulations.
 - ii. The determination for this discount is the responsibility of MelroseWakefield Healthcare.
 - iii. Reference [Appendix C](#) and [Appendix D](#) for additional detail.
- i. MelroseWakefield Healthcare Uninsured and Underinsured Patient Discount Policy:
- i. MelroseWakefield Healthcare will offer a discount to patients of all income levels regardless of

residency who meet the qualifications for “Uninsured and Underinsured Patients” listed in Section III(b) above, fulfill the patient responsibilities of Section III(c) above, and who complete a MelroseWakefield Healthcare financial assistance application.

- ii. All Uninsured and Underinsured patients who meet the conditions of this policy are eligible for a discount of up to 40% on Eligible Services if payment is received, or if a payment plan is agreed to, within 30 days of the initial bill.
 - 1. For Non-Emergency, Non-Urgent services, payment must be made in full, or a payment plan agreed to, prior to service delivery. Should actual charges exceed the estimate, the patient must pay any additional amount owed within 30 days of the initial bill.
 - a. If additional charges are not paid in a timely manner, the entire discount agreement may be reversed and the patient will be billed for full charges.
 - 2. For Emergency or Urgent services, payment must be made, or a payment plan agreed to, within 30 days of the initial bill.
- iii. In evaluating whether to grant a discount under this policy, MelroseWakefield Healthcare may take into account whether a patient is current on all outstanding balances.

j. Basis for Calculating Amounts Charged to Patients:

- i. Following a determination of a patient’s eligibility for the discount programs set forth in Section IV(g) or Section IV(h) above, a patient will not be charged more for eligible services than the amount generally billed (“AGB”) by the Hospital.
- ii. MelroseWakefield Healthcare determines the AGB by first dividing the total payments by total charges for all commercial and Medicare fee-for-service (FFS) and Medicare Managed Care plans in the aggregate for the prior fiscal year to determine the Payment on Account Factor (PAF) for the prior fiscal year. This is generally done in October when the most accurate data from the health plans is available. The minimum MelroseWakefield Healthcare Low Income Patient discount is equal to the inverse of the prior fiscal year’s PAF, which is the AGB.
- iii. AGB Calculation
 Formula: $PAF = \frac{\text{Total Payments}}{\text{Total Charges for commercial, Medicare FFS, and Medicare Managed Care Plans}}$
 AGB = inverse of PAF
- iv. For example, AGB calculation:
 - 1. Total Payment from commercial, Medicare FFS, and Medicare Managed Care plans: \$431
 - 2. Total Charges for commercial, Medicare FFS, and Medicare Managed Care plans: \$1,000
 - 3. PAF: 43.07%
 - 4. MelroseWakefield Healthcare Low Income Patient AGB Discount: 56.93%
- v. MelroseWakefield Healthcare low income patient minimum discount, which is the AGB, is effective 10/1/2018 at 56.93%. These were determined from commercial and Medicare FFS, and Medicare Managed Care plans’ paid claims for the period 10/1/2017 to 9/30/2018.

V. Payment Plan

Interest-free payment plans for Eligible Services will be offered to all patients who meet the criteria set forth in Section III(c) above upon request. Final acceptance of a payment plan is subject to a complete review of the patient’s status and payment history. MelroseWakefield Healthcare will process all patient payment plans. Payment plans are monitored by an outside vendor. Full patient compliance is expected if a payment plan is agreed upon. If a patient misses two consecutive payments, the payment plan is terminated and the Hospital may place the account in Bad Debt in accordance with the procedures and protections set forth in the Hospital’s Credit and Collection Policy (available at www.melrosewakefield.org/FAP). Upon notification from the patient of

changed financial circumstances, the Hospital may re-evaluate the patient's outstanding payment obligation.

- a. Patients that have been determined to be a Low Income Patient or eligible for Medical Hardship under the Massachusetts Health Safety Net program are not required to meet the criteria set forth in Section III(c) prior to the Hospital offering a payment plan. For HSN Low Income or Medical Hardship patients with a balance of \$1,000 or less, such payment plan shall be at least a one-year, interest-free plan with a minimum payment of no more than \$25 per month. For HSN Low Income or Medical Hardship patients with a balance of \$1,000 or more, such payment plan shall be at least a two-year, interest free plan.

VI. Nonpayment

The Hospital maintains a separate Credit and Collection policy that addresses the actions the Hospital may take in the case of nonpayment and includes a list of patients who may be protected under State law from any collection action. Prior to engaging in any extraordinary collection actions under such policy, the Hospital will make a reasonable effort to qualify a patient for financial assistance under this policy by notifying the patient in writing about the available assistance programs and assisting such individual with the completion of the MelroseWakefield Healthcare financial assistance application. The Hospital's separate Credit and Collection policy is readily available to members of the public on the Hospital's website at www.melrosewakefield.org/FAP.

VII. Publication and Dissemination of the FAP

- a. Information about MelroseWakefield Healthcare's financial counselors, who offer financial counseling and financial assistance, and information about the financial assistance policy may be located online at www.melrosewakefield.org/FAP.
 - i. To schedule an appointment with a Financial Counselor by telephone you may call: 781-338-7111.
 - ii. The MelroseWakefield Healthcare Financial Counselors are located at the following MelroseWakefield Healthcare locations:
 1. MelroseWakefield Hospital, 1st Floor near the Porter Street entrance, 585 Lebanon Street, Melrose, MA 02176.
 2. Lawrence Memorial Hospital, next to the Emergency Department, 170 Governors Avenue, Medford, MA 02155.
- b. Internet Posting
 - i. In addition to being available through MelroseWakefield Healthcare financial counselors, the MelroseWakefield Healthcare financial assistance policy, application forms, and a plain language summary are available at: www.melrosewakefield.org/FAP.
 1. This web page may also be accessed from the MelroseWakefield Healthcare homepage (www.melrosewakefield.org) by selecting Patients & Visitors then Financial Assistance Policy.
 2. The website includes ways in which patients can apply for assistance from the Hospital, including a list of financial counselor locations and a central phone number to schedule an appointment with a financial counselor. The website lets patients know that the application forms and financial assistance are free.
- c. The Hospital widely publicizes the availability of financial assistance under this policy in the following ways:
 - i. Large, conspicuous signage (8" X 14") is posted in all portals of entry and other high traffic areas, including the emergency department, financial coordination and customer service.
 - ii. Plain language brochures that advertise the availability of MelroseWakefield Healthcare financial assistance options are displayed in the emergency department and admission areas.
 - iii. The plain language summary of the FAP is available to patients as part of the Hospital's intake and discharge process.
 - iv. Copies of the Hospital's Financial Assistance Policy, application, and plain language summary are

made available to patients, free of charge, that request a copy, in person, or by mail and for any patient who has specific questions.

- v. Materials, including the policy, application form and plain language summary are available in English, Chinese, Spanish, Vietnamese, Portuguese, Russian, Greek, Hindi, Italian, Creole, and Arabic.
- vi. Hospital community program staffs are educated about the FAP and are instructed to inform and notify their community constituents of the availability of financial assistance at MelroseWakefield Healthcare.

VIII. Other Provisions:

a. Medicare Bad Debt:

- i. This policy may also be used to verify the indigence of a patient for the purposes of qualifying their balances resulting from a co-insurance or deductible from services covered by Medicare where Medicare Bad Debt is applicable. The determinants will be the patient's current income of their reported asset levels. To qualify, the patient must have an income of less than 201% of the FPL and assets of less than \$10,000 for the first family member with an additional \$3,000 allowed for each additional family member. Asset determinations will never include the primary residence or the primary automobile. The patient's completion of a MelroseWakefield Healthcare financial assistance application will be proof that the patient has an inability to use assets to pay their outstanding balances.

b. Case-By-Case Evaluation:

- i. Patients are encouraged to bring their unique financial situations to the attention of Financial Counselors or Patient Accounts. MelroseWakefield Healthcare may extend discounts beyond the provisions in this policy on a case-by-case basis to recognize unique cases of financial hardship.
- ii. Existing discounts that go beyond this policy may be honored with the approval of the Hospital CFO.

IX. Board Approval

The MelroseWakefield Healthcare FAP was approved by the MelroseWakefield Healthcare Board of Trustees on January 24, 2019.

Appendix A– MelroseWakefield Healthcare Locations, Participating

For a list of participating entities, please see www.melrosewakefield.org/FAP

Appendix B: MelroseWakefield Healthcare Provider Affiliate List, Non-Participating Entities

For a list of non-participating entities, please see www.melrosewakefield.org/FAP

Appendix C: MelroseWakefield Healthcare Financial Assistance Discount Amounts

Family Size	100% FPL	Up to 150% FPL	Up to 300% FPL	Greater Than 301 % FPL
1	\$12,492	\$18,744	\$37,476	\$37,477
2	\$16,920	\$25,368	\$50,736	\$50,737
3	\$21,336	\$32,004	\$63,996	\$63,997
4	\$25,752	\$38,628	\$77,256	\$77,257
5	\$30,180	\$45,264	\$90,516	\$90,517
6	\$34,596	\$51,888	\$103,776	\$103,777
7	\$39,012	\$58,524	\$117,036	\$117,037
8	\$43,440	\$65,148	\$130,296	\$130,297
Each Person > 8	\$4,428	\$6,636	\$13,260	\$13,261
Discount		100%	58%	40%
Expected Patient Payment		0%	42%	60%

FPL is defined as Federal Poverty Level, released January 2019, as defined by the Federal Register

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



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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If NO, are you a permanent resident, legally residing in the United States? <input type="checkbox"/> YES <input type="checkbox"/> 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		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you submitted a Medicaid application within the last six (6) months?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have a pending or approved Medicaid application?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Has your Medicaid application been denied?	
<input type="checkbox"/> YES <input type="checkbox"/> 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:		

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?		
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> 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: _____

EXHIBIT E

[Approval Letter – Partial Discount]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

We received your application for assistance with hospital bills under the MelroseWakefield Healthcare Financial Assistance Policy. Upon review of your application and supporting documents, we have determined that you are eligible for a reduction in charges.

Hospital bills for dates of service ___/___/___ through ___/___/___ totaling \$_____, will be reduced to \$_____.

We will be in touch to assist you in making payment arrangements for the remaining balance. Please note that until the discounted amount has been paid in full, you will continue to receive bills. Once all payments have cleared, the balance will be adjusted and your bills will be considered paid in full. Also please note that the discount in this program does not apply to any co-payment, co-insurance or deductible amounts that continue to be your responsibility as per the terms of your health insurance.

This approval shall be in effect for six (6) months. If you disagree with this decision or feel that you may qualify for additional discounts, please contact the financial counselor at the number listed below.

Sincerely,

Name

Position

Phone number

[Approval Letter – 100% Discount]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

We received your application for assistance with hospital bills under the MelroseWakefield Healthcare Financial Assistance Policy. Upon review of your application and supporting documents, we have determined that you are eligible for services at no cost to you.

Hospital bills for dates of service ___/___/___ through ___/___/___ totaling \$_____, will be reduced to \$0.

You should not receive any further bills from us for these services.

This approval shall be in effect for six (6) months. If you have any questions, please contact the financial counselor at the number listed below.

Sincerely,

Name

Position

Phone number

[Re-determination Letter – Partial Discount to 100% discount]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

We are writing to follow up on our original determination dated ___/___/____. In that determination we concluded that you were only eligible for reduced hospital charges under the Melrose Wakefield Healthcare Financial Assistance Policy.

At your request and based on updated information on income and/or family composition or circumstances, we have determined that you are now eligible for hospital services at no cost to you. Therefore, Hospital bills for dates of service ___/___/____ through ___/___/____ totaling \$_____, will be reduced to \$0.

You should not receive any further bills from us for these services.

This approval shall be in effect for a period of six (6) months. If you have any questions, please call the financial counselor at the number listed below.

Sincerely,

Name

Position

Phone Number

[Re-determination Letter – Not Previously Eligible for 100% Discount]

Date

Name

Street

City, state, zip code

RE: patient account number(s):

Dear _____,

We are writing to follow up on our original determination dated ___/___/____. In that determination we concluded that you were not eligible for financial assistance under the MelroseWakefield Healthcare Financial Assistance Program.

At your request and based on updated information on income and/or family composition or circumstances, we have determined that you are now eligible for hospital services at no cost to you. Therefore, Hospital bills for dates of service ___/___/____ through ___/___/____ totaling \$_____, will be reduced to \$0.

You should not receive any further bills from us for these services.

This approval shall be in effect for a period of six (6) months. If you have any questions, please call the financial counselor at the number listed below.

Sincerely,

Name

Position

Phone number

[Re-determination Letter – Previously Not Eligible for Partial Discount]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

We are writing to follow up on our original determination dated ___/___/____. In that determination we concluded that you were not eligible for financial assistance under the MelroseWakefield Healthcare Financial Assistance Program.

At your request and based on updated information on income and/or family composition or circumstances, we have determined that you are now eligible for a reduction in hospital charges.

Hospital bills for dates of service ___/___/____ through ___/___/____ totaling \$_____, will be reduced to \$_____.

We will be in touch to assist you in making payment arrangements for the remaining balance. Please note that until the discounted amount has been paid in full, you will continue to receive bills. Once all payments have cleared, the balance will be adjusted and your bills will be considered paid in full. Also please note that the discount in this program does not apply to any co-payment, co-insurance or deductible amounts that continue to be your responsibility as per the terms of your health insurance.

This approval shall be in effect for six (6) months. If you disagree with this decision or feel that you may qualify for additional discounts, please contact the financial counselor at the number listed below.

Sincerely,

Name

Position

Phone number

[Re-determination Letter – Original Decision Stands – Partial]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

We are writing to follow up on our original determination dated ___/___/__. In that determination we concluded that you were only eligible for reduced hospital charges under the MelroseWakefield Healthcare Financial Assistance Policy.

At your request, we have reviewed and reconsidered our original decision on your application and have determined that based on all the information provided, our original decision stands and you continue to only be eligible for a partial discount.

As noted on our original determination letter, bills for hospital services in the amount of \$_____ for dates of service ___/___/__ through ___/___/__ remain the same.

Kindly send your total payment promptly or call the financial counselor listed below if you need to make special payment arrangements.

If you disagree with this decision or have any questions, please contact the financial counselor listed below.

Sincerely,

Name

Position

Phone Number

[Re-determination Letter – Original Decision Stands – Not Eligible]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

We are writing to follow up on our original determination dated ___/___/__. In that determination we concluded that you were not eligible for assistance under the MelroseWakefield Healthcare Financial Assistance Program.

At your request, we have reviewed and reconsidered the original decision on your application and have determined that based on all the information provided, the original decision stands and you are not eligible for assistance under the program.

Kindly send your total payment promptly or call the financial counselor listed below if you need to make special payment arrangements.

If you disagree with this decision or have any questions, please contact the financial counselor listed below.

Sincerely,

Name

Position

Phone Number

[Denial Letter – General]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

Thank you for your application for financial assistance with your hospital bills under the Melrose Wakefield Healthcare Financial Assistance Policy.

We have reviewed your application and supporting documentation and determined that you are not eligible for discounts under the program. The determination was made by comparing your income and family size with Federal Poverty Level (FPL) guidelines. More specifically, your household income was determined to be higher than that allowed.

If you disagree with this decision or have recently had a change in circumstances, we will gladly reconsider your application in light of any new information regarding your income, household size or circumstances. If you would like to have your application reviewed, please send in relevant documents or, call the financial counselor at the number listed below for any questions.

Sincerely,

Name

Position

Phone Number

[Denial Letter – Incomplete Application]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

We are in receipt of an application dated ___/___/___ for assistance with your hospital bills under the MelroseWakefield Healthcare Financial Assistance Policy.

As of today, we have not received the documentation necessary to process the application and give you a determination. For this reason, we are denying your application for assistance at this time.

If you are still interested in being considered for financial assistance, we encourage you to complete a new application and send it to us with all supporting documentation. We will gladly review it and will notify you if you are eligible for any financial assistance.

If you have any questions, please contact the financial counselor listed below.

Sincerely,

Name

Position

Phone Number

[Denial Letter – Services Not Eligible]

Date

Name

Street

City, state, zip code

RE: patient account number(s): _____

Dear _____,

Thank you for your application dated ___/___/___ for financial assistance with your hospital bills under the Melrose Wakefield Healthcare Financial Assistance Program.

We regret to inform you that the services you received on ___/___/___ are not considered medically necessary and as such are not eligible for any financial assistance under the program.

Kindly send your total payment promptly or call the financial counselor listed below if you need to make special payment arrangements.

If you disagree with this decision or have any questions, please contact the financial counselor listed below.

Sincerely,

Name

Position

Phone Number