Dear Patient,

Attached is the Financial Assistance Application for Northeast Hospital Corporation, Winchester Hospital, and Lahey Clinic Hospital, Inc. Please fill out in its entirety and return with all required documentation. Incomplete applications may result in denial of financial assistance.

The deadline to return the application is 240 days from the first billing statement for the services which financial assistance is being requested.

Northeast Hospital Corporation, Winchester Hospital, and Lahey Clinic Hospital, Inc. and their affiliates are dedicated to providing financial assistance to patients who have healthcare needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay for medically necessary care based their individual financial situation.

If you have questions please contact Financial Counseling at the number listed below.

Thank you.

Return Application to:

Financial Counseling Department
Lahey Hospital & Medical Center
41 Mall Road
Burlington MA 01803
781-744-8815

Financial Assistance Application for Charity Care

Please Print

Today's Date: _____ Social Security #_____

Medical Record Number: _____

Patient Name: _____

Address: _____
Street Apt. Number

_____ _____ _____
City State Zip Code

Date of Hospital Services: _____ Patient Date of Birth_____

Did the patient have health insurance or Medicaid** at the time of hospital service? Yes ☐ No ☐
If "Yes", attach a copy of the insurance card (front and back) and complete the following:

Name of Insurance Company: _____ Policy Number: _____

Effective Date: _____ Insurance Phone Number: _____

**Prior to applying for financial assistance, you must have applied for Medicaid in the past 6 months and will need to show proof of denial.

Note*: Financial assistance may not apply if a Health Savings Account (HSA), Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or similar fund designated for family medical expenses has been established. Payment from any established fund is due before assistance can be provided.*

To apply for financial assistance complete the following:
List all family members including the patient, parents, children and/or siblings, natural or adopted, under the age 18 living at home.

Family Member	Age	Relationship to Patient	Source of Income or Employer Name	Monthly Gross Income
1.				
2.				
3.				
4.				

In addition to the Financial Assistance Application we also need the following documentation attached to this application:

- Current state or federal income tax returns
- Current Forms W2 and/or Forms 1099
- Four most recent payroll stubs
- Four most recent checking and/or savings account statements
- Health savings accounts
- Health reimbursement arrangements

- Flexible spending accounts

If these are not available, please call the Financial Counseling Unit at (781) 744-8815 to discuss other documentation they may provide.

By my signature below, I certify that I have carefully read the Financial Assistance Policy and Application and that everything I have stated or any documentation I have attached is true and correct to the best of my knowledge. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Applicant's Signature: _____ _____

Relationship to Patient: _____

Date Completed: _____

If your income is supplemented in any way or you reported $0.00 income on this application, have the Support Statement below completed by the person(s) providing help to you and your family.

Support Statement

I have been identified by the patient/responsible party as providing financial support. Below is a list of services and support that I provide.

_____

_____

_____

_____

_____

_____

_____

I hereby certify and verify that all of the information given is true and correct to the best of my knowledge. I understand that my signature will not make me financially responsible for the patient's medical expenses.

Signature: _____ Date Completed: _____

Please allow 30 days from the date the completed application is received for eligibility determination.

If eligible, financial assistance is granted for six months from the date of approval and is valid for all Beth Israel Lahey Health affiliates as set forth in Appendix 5 of their respective Financial Assistance Policies:

- Anna Jaques Hospital
- Addison Gilbert Hospital
- BayRidge Hospital
- Beth Israel Deaconess Medical Center-Boston
- Beth Israel Deaconess Milton
- Beth Israel Deaconess Needham
- Beth Israel Deaconess Plymouth
- Beverly Hospital
- Lahey Hospital & Medical Center, Burlington
- Lahey Medical Center, Peabody
- Mount Auburn Hospital
- New England Baptist Hospital
- Winchester Hospital

Staff Only.
Application Received by:
AJH ☐
AGH ☐
BayRidge ☐
BIDMC ☐
BID Milton ☐
BID Needham ☐
BID Plymouth ☐
Beverly ☐
LHMC ☐
LMC Peabody ☐
MAH ☐
NEBH ☐
WH ☐

Date Received: