Lowell General Hospital

APPLICATION FOR FINANCIAL ASSISTANCE

This form will be used to determine if you are eligible for the hospital's financial assistance program or if you may qualify for health care coverage through other programs. If you are applying for someone else, please answer all the questions using the applicant's information. If a section or question does not apply to you or any family member, please write "N/A". If you need additional space, please use another sheet of paper.

APPLICANT INFORMATION

LAST NAME _____ FIRST NAME _____ MI ____ SOCIAL SECURITY NUMBER (SSN) OR TAX ID NUMBER _____

STREET ADDRESS _____ DATE OF BIRTH __ __ / __ __ / __ __ __ __

CITY _____ STATE _____ ZIP _____ HOME TELEPHONE _____

MAILING ADDRESS _____ WORK/MOBILE TELEPHONE _____
(IF DIFFERENT FROM STREET ADDRESS)

CITY _____ STATE _____ ZIP _____ MALE ☐ FEMALE ☐ GENDER

YES ☐ NO ☐ ARE YOU HOMELESS?

YES ☐ NO ☐ ARE YOU PREGNANT?

If you are applying for someone else, please complete this section as the contact person.

LAST NAME _____ FIRST NAME _____ MI ____ RELATIONSHIP TO APPLICANT: _____

STREET ADDRESS _____ HOME TELEPHONE _____

CITY _____ STATE _____ ZIP _____ WORK/MOBILE TELEPHONE _____

MAILING ADDRESS _____
(IF DIFFERENT FROM STREET ADDRESS)

CITY _____ STATE _____ ZIP _____

FAMILY INFORMATION

Please list the people in your family that live with you. Include your **Spouse** and any dependent **children under age 18** that either of you may have that live with you. If you are applying for a child under age 18, please include any brothers or sisters under age 18 who live with the child, and the child's parent or parents who live with the child.

Name of Family Member	SSN or TIN *(if one has been issued)*	Relationship	Date of Birth	Gender M F	Pregnant Y N
				☐ ☐	☐ ☐
				☐ ☐	☐ ☐
				☐ ☐	☐ ☐
				☐ ☐	☐ ☐
				☐ ☐	☐ ☐

EARNED INCOME

Please complete this section about income (before taxes and deductions) for each family member who works.

Name of Working Family Member	Amount Earned	How Often?	Facility Use Only Total Income
Employer Name & Address			

Number of people who work for this employer: ☐ under 50 ☐ 51-200 ☐ over 200 ☐ Don't know

Name of Working Family Member	Amount Earned	How Often?	Facility Use Only Total Income
Employer Name & Address			

Number of people who work for this employer: ☐ under 50 ☐ 51-200 ☐ over 200 ☐ Don't know

OTHER INCOME

Please complete this section about other income (before taxes and deductions) for each family member who receives other income.
Other income is money you receive that does not come from an employer.

Type of Income	Family Member(s) Receiving Income	Amount Received	How Often (Check one)	Facility Use Only *Total Income*
Social Security			Weekly, Monthly, Annually	
Railroad Retirement			Weekly, Monthly, Annually	
Veteran's Benefits			Weekly, Monthly, Annually	
Retirement Funds			Weekly, Monthly, Annually	
Annuities			Weekly, Monthly, Annually	
Pensions			Weekly, Monthly, Annually	
Child Support			Weekly, Monthly, Annually	
Alimony			Weekly, Monthly, Annually	
Unemployment			Weekly, Monthly, Annually	
Worker's Comp.			Weekly, Monthly, Annually	
Rental Income			Weekly, Monthly, Annually	
Trust Income			Weekly, Monthly, Annually	
Transitional Assistance			Weekly, Monthly, Annually	
EAEDC			Weekly, Monthly, Annually	
Dividend Income			Weekly, Monthly, Annually	
Bank Account Income			Weekly, Monthly, Annually	
Other			Weekly, Monthly, Annually	

*If you or anyone listed on page 1 are **required** to make payments for alimony, child support, or a personal needs allowance for a family member in a nursing home, please fill out the section below.*

Type of Payment	Recipient	Amount Paid	How Often (check one)	Facility Use Only *Total Payment*
Alimony			Weekly, Monthly, Annually	
Child Support			Weekly, Monthly, Annually	
Personal Needs Allowance			Monthly	

OTHER INSURANCE

If you have health insurance, you may still be eligible for financial assistance to pay for amounts such as copayments and deductibles.

1. Are you covered under any health insurance policy, including foreign coverage and medicare? ☐ YES ☐ NO
   If yes, please provide the following information:

Policy Holder: _____ Insurer: _____ Policy Number: _____

Policy Holder: _____ Insurer: _____ Policy Number: _____

2. Are you seeking financial assistance because of a work-related accident or injury? ☐ YES ☐ NO
3. Are you seeking financial assistance because of a motor vehicle accident? ☐ YES ☐ NO
4. Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury? ☐ YES ☐ NO
5. Are you a college student? ☐ YES ☐ NO If yes: Full time? ☐ Part time? ☐
6. Do you have an application pending for any of these programs? (please check all that apply)

☐ Children's Medical Security Plan	☐ Healthy Start	☐ EAEDC	☐ Commonwealth Care
☐ Transitional Assistance	☐ Boston HealthNet	☐ Cambridge Network Health	☐ Commonwealth Bridge
☐ Mass Health	☐ CenterCare	☐ Health Safety Net	☐ Other: _____

APPLICANT SIGNATURE

Please Read this section carefully and sign at the bottom.

I authorize my employer and my health insurer to give to this hospital or community health center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking financial assistance because of an accident or other incident, and I receive money because of that accident or incident from any sources, such as workers' compensation or an insurance carrier, I will repay the hospital or community health center for any medical services paid by the financial assistance pool. I give this hospital or community health center the right to collect payments from insurers for medical care as appropriate.

While I am eligible for financial assistance, I agree to tell the hospital of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for financial assistance.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.
I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, without my prior approval.

_____ _____
Signature of Applicant Date

If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.

_____ _____
Signature of authorized representative Date

The representative that assisted you with this application: _____ Phone: _____