Massachusetts Eye and Ear Infirmary
Financial Assistance Application

Patient and Family Information (Use the back of this form if you need more room):

Date: _____
Patient Name: _____
Date of Birth: _____
Address: _____
City, State, Zip: _____
Phone Number: _____

Financially Responsible Party or Parties:

Relationship of Financially Responsible Party or Parties to Patient:

☐ Self ☐ Parent ☐ Spouse
☐ Adult Child ☐ Sibling ☐ Other _____

Did the patient have health insurance at the time of services:

☐ Yes ☐ No

If yes, please attach a copy of the insurance card (front and back) and complete the following:

Name of Insurance Company: _____
Policy Number: _____
Group Number: _____
Subscriber's Name _____

List family members, including patient, spouse, parents, children and siblings living at the patient's home:

Family Members		Age	Relationship to Patient
1.			
2.			
3.			
4.			

Income: List ALL income for responsible parties including gross (pretax) wages, rental income, unemployment, Social Security benefits, pension income, child support, alimony, etc.:

Family Member		Source of Income or Employer	Monthly Income
1.			
2.			
3.			

Please provide **copies** of two consecutive pay stubs, award letters or statements supporting other income, or the most recent federal tax return.

Please continue form on next page.

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Assets: List financial assets such as savings and checking accounts, CDs, stocks, and mutual funds. Do not include retirement or deferred-compensation plans:

Financial Institution		Type of Account	Account Number	Balance
1.				
2.				
3.				
4.				

Please provide **copies** of a current statement for each account.

Medical Expenses: If you have family member medical expenses that you would like to have taken into account in determining how much you can afford to pay, please complete the following:

Hospital Expenses:

Name of Facility		Amount Paid in Last 12 Months	Amount Still Due	Patient Name
1.				
2.				
3.				

Physician Expenses:

Name of Physician or Practice		Amount Paid in Last 12 Months	Amount Still Due	Patient Name
1.				
2.				
3.				

Other Medical Bills:

Name of Provider		Amount Paid in Last 12 Months	Amount Still Due	Patient Name
1.				
2.				
3.				

Please provide **copies** of all statements showing amounts still due.

Please continue form on next page.

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Extraordinary Financial Circumstances: Please complete all information that applies:

Unemployment:

☐ Responsible Party is unemployed

Date last worked: _____

Housing Payment Overdue:

Home Address	Rent or Own	Amount Overdue (Rent or Mortgage Principal and Interest, Real Estate Taxes and Insurance)

Please provide a **copy** of current statements showing amounts past due.

Explain any other extraordinary financial circumstances that the responsible party would like to have taken into account in determining how much he or she can afford to pay:

Describe Other Extraordinary Financial Circumstances	Monthly Payment	Amount Still Due	Amount Overdue

Please provide **copies** of any additional documentation supporting other extraordinary financial circumstances that you would like to have taken into account in determining how much you can afford to pay.

Other Responsible Parties: Please indicate if there is any other person not listed above who is legally responsible for the payment of the patient's medical expenses, such as a guardian.

☐ Yes, there is another person who is legally responsible for the patient's medical expenses.
☐ No, there isn't another person who is legally responsible for the patient's medical expenses.

If yes, please complete the following:

Name	**Address**	**Role or Relationship**

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Please continue form on next page.

Evidence of Medicaid Denial: Please provide copies of written denials from either MassHealth (when the application was not submitted directly by Mass. Eye and Ear) or the Medicaid program in your home state.

The responsible party acknowledges that he or she is required to report to Mass. Eye and Ear any insurance changes or updates.

Do not send original documents. Send photocopies only. Originals will not be returned.

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Certification: By my signature below, I certify that I have carefully read this application and everything I have stated and any documentation attached is true and correct to the best of my knowledge and belief. **I understand that it is unlawful to knowingly submit false information to obtain financial assistance.**

Signature of Responsible Party or Parties:

_____

Date _____

For any questions regarding this application or the Massachusetts Eye and Ear Financial Assistance Policy, please contact our Financial Coordinators by phone at 617-573-5664 or by email at FINANCIAL_COORDINATORS @MEEI.HARVARD.EDU.

Return this application to:

Massachusetts Eye and Ear
243 Charles Street
Boston, MA 02114-3096
Attn: Financial Coordinators