APPLICATION FOR HOLYOKE MEDICAL CENTER (HMC) FINANCIAL ASSISTANCE

THINGS TO KNOW

HOW TO APPLY

You can access the application and submit in any of the following ways:

- **Visit** HMC to apply in person.
- **Call** HMC Financial Counselor to request an application be mailed out to you.
- **Online** at www.holyokehealth.com to download an application and mail to:

  Holyoke Medical Center
  ATTN: Financial Counselor
  575 Beech Street
  Holyoke, MA 01040

Use of this application

- This application will be used to determine if you are eligible for HMC Financial Assistance or if you may qualify for health care coverage through other programs.
- If you are applying for someone else, please answer all questions using the applicant's information.

Who can use this application?

- Those who fall under the Federal Poverty Level of 300%; and
- Anyone who has applied for and have been denied Financial Assistance under the State of MA Financial Assistance Programs i.e. HSN, MH etc.; and
- Does not have any form of insurance to cover services rendered that are medically necessary; and
- Is a Massachusetts resident; however, if applicant is an out of state resident that can provide evidence of applying for ad being denied public financial assistance in their own state, we can also apply this discount.

What you may need to apply

- **Proof of Income:** Most recent Income Tax Return with W-2, 3 most recent paystubs, or wage and tax statements.
- **Government issued picture ID**
- **Denial from the State Financial Assistance Programs:** MH or HSN denial letter.

General instructions

- Please **print clearly and answer all questions completely**.
- Please send **all** pages of your application with supporting documents.

What happens next?

You will receive a letter in the mail within 30 days from the date the application is received; with a decision whether the application has been approved or denied for Financial Assistance.

APPLICANT INFORMATION

Name:

Last Name | First Name | MI | Social Security Number/ Tax I.D. Number

Street Address | (Home) ( ) (Work) ( )

City | State | Zip | Telephone Number

Mailing Address *(if different from street address)* | ☐ Yes ☐ No Are you homeless?

/ / Date of Birth | ☐ Male ☐ Female Gender | ☐ 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) ( ) (Work) ( )

City | State | Zip | Telephone Number

Mailing Address *(if different from street address)*

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 18 who live with this child, and the child's parent or parents who live with the child.

Name of Family Member	SSN or TIN	Relationship	Date of Birth	Gender M	Gender F	Pregnant Y	Pregnant 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?	**Office Use Only** *Total Income*
Employer's Name & Address			
Number of people who work for this company: ☐ under 50 ☐ 51 - 200 ☐ over 200 ☐ Don't know			

Name of working Family Member	Amount Earned	How Often?	**Office Use Only** *Total Income*
Employer's Name & Address			
Number of people who work for this company: ☐ 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 *(Circle one)*	**Facility Use Only** *Total Income*
Social Security			Wkly / Monthly / Yr.	
Railroad Retirement			Wkly / Monthly / Yr.	
Veteran's Benefits			Wkly / Monthly / Yr.	
Retirement Funds			Wkly / Monthly / Yr.	
Annuities			Wkly / Monthly / Yr.	
Pensions			Wkly / Monthly / Yr.	
Child Support			Wkly / Monthly / Yr.	
Alimony			Wkly / Monthly / Yr.	
Unemployment			Wkly / Monthly / Yr.	
Workers Comp.			Wkly / Monthly / Yr.	
Rental Income			Wkly / Monthly / Yr.	
Trust Income			Wkly / Monthly / Yr.	
EAEDC			Wkly / Monthly / Yr.	
Other			Wkly / Monthly / Yr.	

Other Insurance

1. Are you covered under any health insurance policy, including foreign coverage and Medicare? **If yes, please provide the following information:** ☐ Yes ☐ No

Policy Holder: _____ Insurer: _____ Policy#: _____

Policy Holder: _____ Insurer: _____ Policy#: _____

2. Are you seeking HMC Financial Assistance because of a work-related accident or injury? ☐ Yes ☐ No

3. Are you seeking HMC 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? *(check all that apply)*

☐ Children's Medical Sec. Plan ☐ MassHealth ☐ EAEDC

☐ Transitional Assistance ☐ Healthy Start ☐ CenterCare

☐ Other _____

Were you denied coverage? ☐ Yes ☐ No

Reason: _____

(If you were denied from any of these programs, please provide proof of denial)

Optional Questions

This question is asked for data collection and analysis purposes only and in no way will be used to determine HMC Financial Assistance eligibility.

Race

☐ American Indian or Alaskan Native ☐ Black, not Hispanic ☐ Hispanic

☐ Asian or Pacific Islander ☐ White, not Hispanic ☐ Other: _____

Assignment Of Rights

Please read this section carefully and sign at the bottom.

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

All information in this application is true to the best of knowledge. I agree to provide documentation upon request. I understand that this hospital cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, 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 Rep.: _____ Date: _____

Patient's Name: _____ SS# _____

Approved/Denied: _____ Date: _____
(Financial Counselor's Signature)

See Guideline below: Federal Poverty Guideline

Persons in Family Or household	2020 300% Family Limit
1	$ 38,280
2	51,720
3	65,160
4	78,600
5	92,040
6	105,480
7	118,920
8	132,360

**For family sizes over 8 per household, please add $13,440 per family member over 8 to the 2020 Federal Poverty Guidelines.

Calculation…….

A) Family Size: _____

B) Family Income: $_____

C) 300% Family Limit: $_____

Is Line B less than Line C: YES/NO If yes, you are approved for Holyoke Medical Center's Financial Assistance

If no, Please see Financial Counselor for Payment plan options

Your financial assistance application is effective: _____ and
Ends: _____

ACCT #	BILLED AMNT	DISCOUNT	NEW PT BAL	fc/intials
_____	$_____	$_____	$_____	____
_____	$ _____	$ _____	$_____	____
_____	$ _____	$ _____	$_____	____