Holyoke Medical Center, Inc.
575 Beech Street
Holyoke, MA 01040

Financial Assistance Policy
FY 2016

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Introduction

This policy applies to Holyoke Medical Center ("the hospital") and specific locations and providers as identified in this policy.

The hospital is the frontline caregiver providing medically necessary care for all people who present to its facility and locations regardless of ability to pay. The hospital offers this care for ***all*** patients that come to our facility 24 hours a day, seven days a week, and 365 days a year. As a result, the hospital is committed to providing all of our patients with high-quality care and services. As part of this commitment, the hospital works with individuals with limited incomes and resources to find available options to cover the cost of their care.

The hospital will help uninsured and underinsured individuals apply for health coverage through a public assistance program or the hospital's financial assistance program (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net, and Medical Hardship), and work with individuals to enroll as appropriate. Assistance for these programs is determined by reviewing, among other items, an individual's household income, assets, family size, expenses, and medical needs.

While the hospital assists patients in obtaining health coverage through public programs and financial assistance through other sources whenever appropriate including the hospital, the hospital may also be required to appropriately bill for and collect specific payments, which may include but not be limited to, applicable co-payments, deductibles, deposits, and other amounts for which the patient agrees to be responsible. When registering for services or if receiving a bill, the hospital encourages patients to contact our staff to determine if they and/or a family member are in need of and eligible for financial assistance.

In working with patients to find available public assistance or coverage through the hospital's financial assistance, the hospital does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability in its policies or in its application of policies, concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, determination that an individual qualifies for Low Income Patient status as determined by the Massachusetts MassHealth/Connector eligibility system, or attestation of information to determine Low Income patient status. As such, this policy was reviewed and approved by the Valley Health Systems Board of Trustees.

While we understand that each individual has a unique financial situation, information and assistance regarding eligibility for public assistance programs and/or coverage through the hospital's financial assistance program may be obtained by contacting the Financial Counseling department located on the first floor of the hospital at (413) 534-2603 or (413) 535-4723 between the hours of 8:00 am to 4:00pm Monday through Friday.

More information about this policy and the hospital's financial assistance program, including the application form and a plain language summary of the financial assistance policy, are available on the hospital's website: www.holyokehealth.com under the Patient & Visitor Information section.

The actions that the hospital may take in the event of nonpayment are described in the hospital's separate billing and collections policy. Members of the public may obtain a free copy of the billings and collections policy at www.holyokehealth.com under the Patient & Visitor Information section.

I. Coverage for Medically Necessary Health Care Services

The hospital provides medically necessary medical and behavioral health care services for all patients who present at a hospital location regardless of their ability to pay. Medically necessary services includes those that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity. Medically Necessary Services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act.

The treating medical professional will determine the type and level of care and treatment that is necessary for each patient based on their presenting clinical symptoms and following applicable standards of practice. The hospital follows the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination for patients who present at a hospital location seeking emergency services to determine whether an emergency medical condition exists.

Classification of emergency and nonemergency services is based on the following general definitions, as well as the treating clinician's medical determination. The definitions of emergency or urgent care services provided below are further used by the Hospital for purposes of determining allowable emergency and urgent bad debt coverage under the hospitals financial assistance program, including the Health Safety Net.

A. Emergency and Urgent Care Services

Any patient who presents at a hospital requesting emergency assistance will be evaluated based on the presenting clinical symptoms without regard to the patient's identification, insurance coverage, or ability to pay. The hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that patients pay before receiving treatment for emergency medical conditions, or interfering with the screening for and providing of emergency medical care by first discussing the hospital financial assistance program or eligibility for public assistance programs.

a. Emergency Level Services includes treatment for:
    i. A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, such *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 bodily functions, or serious dysfunction of any bodily organ or part,* or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395dd(e)(1)(B).
    ii. In accordance with federal requirements, EMTALA is triggered for anyone who presents to a hospital's property requesting examination or treatment of an

emergency (as defined above) or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, unscheduled persons present themselves at the emergency department. However, unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient/outpatient unit, clinic, or other ancillary area will also be evaluated for and possibly transferred to a more appropriate location for an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions, or any such other service rendered to the extent required under EMTALA, will be provided to the patient and will qualify as emergency level care. The determination that there is an emergency medical condition is made by the treating clinician or other qualified medical personnel of the hospital as documented in the hospital medical record.

b. Urgent Care Services include treatment for the following:
    i. Medically Necessary Services provided in an Acute Hospital after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such *that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing a patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part.* Urgent Care 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. Urgent Care Services do not include Primary or Elective Care.

B. Non-Emergent, Non-Urgent Services:

For patients who (1) the treating clinician determines is non-emergent or non-urgent level care or (2) seek care and treatment following stabilization of an emergency medical condition, the hospital may deem that such care is primary or elective services.

a. Primary or Elective Services includes medical care that is not an Urgent or Emergency level of care and is required by individuals or families for the maintenance of health and the prevention of illness. Typically, these services are medical or behavioral health procedures/visits scheduled in advance or on the same day by the patient or by the health care provider at a hospital location including but not limited to the main campus, a remote site or location, as well as an affiliated physician office, clinic, or community health center. Primary Care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse practitioners or physician assistants in a primary care service. Primary Care does not require the specialized resources of an Acute Hospital emergency department and excludes Ancillary Services and maternity care services.
b. Non-emergent or non-urgent health care services (i.e., primary or elective care) may be delayed or deferred based on the consultation with the hospital's clinical staff, as well as the patient's primary care or treating provider if available and as appropriate. The hospital may further decline to provide a patient with non-emergent, non-urgent services if the patient is medically stable and the hospital is unable to obtain from the patient or other sources appropriate payment source or eligibility information for a public or private health insurance to cover the cost of the non-emergent and non-urgent care. Coverage for healthcare services, including medical and behavioral health, is determined and outlined in a public and private health insurer's medical necessity and coverage manuals. While the hospital will attempt to determine coverage based on the patient's known and available

insurance coverage, it may bill the patient if the services are not a reimbursable service and the patient has agreed to be billed.

c. Coverage from a public, private, or hospital based financial assistance program may not apply to certain primary or elective procedures that are not reimbursable by such coverage options. If the patient is not sure if a service is not covered, they should contact the Financial Counseling department located on the first floor of the hospital at (413) 534-2603 or (413) 535-4723 between the hours of 8:00 am to 4:00pm Monday through Friday to determine what coverage options are available.

C. Hospital Locations providing medically necessary services and covered by the Financial Assistance Policy:

The hospital's financial assistance policy covers the following locations where patients can also obtain information on the availability of public assistance programs:

- Holyoke Medical Center, 575 Beech Street, Holyoke, MA 01040, (413) 534-2525 and all affiliated sites.

In addition, the hospital financial assistance policy covers those Emergent, Urgent, and Primary care services provided by the following provider types within the hospital locations listed above:

- Rheumatology
- Anesthesiology
- Orthopedics
- General & Specialty Surgery
- Cardiovascular
- Urology
- Bariatrics
- Endocrinology
- Hematology/Oncology
- Obstetrics/Gynecology
- Gastroenterology
- Pathology
- Critical Care
- Psychiatry/Psychology

A list of providers specifying which are covered under this policy and which are not may be obtained free of charge, both online and on paper in the following manner:

- Online go to www.holyokehealth.com under the Patient & Visitor Information section
- For a paper listing, contact the Financial Counseling department at (413) 535-4723 or (413) 534-2603

II. Public Assistance Programs and Hospital Financial Assistance

A. General Overview of Health Coverage and Financial Assistance Programs

Hospital patients may be eligible for free or reduced cost of health care services through various state public assistance programs as well as the hospital financial assistance programs (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net, and

Medical Hardship. Such programs are intended to assist low-income patients taking into account each individual's ability to contribute to the cost of his or her care. For those individuals that are uninsured or underinsured, the hospital will, when requested, help them with applying for either coverage through public assistance programs or hospital financial assistance programs that may cover all or some of their unpaid hospital bills.

B. State Public Assistance Programs

The Hospital is available to assist patients in enrolling into state health coverage programs. These include MassHealth, the premium assistance payment program operated by the state's Health Connector, and the Children's Medical Security Plan. For these programs, applicants can submit an application through an online website (which is centrally located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from hospital financial counselors (also called certified application counselors) with submitting the application either on the website or through a paper application.

C. Hospital Financial Assistance

The Hospital also provides financial assistance to patients whose income demonstrates an inability to pay for all or a portion of services provided. Patients who are Massachusetts residents and/or in the Hospital's service area may be required to complete their state's application for Medicaid coverage or subsidized health insurance prior to seeking coverage through the hospital's own financial assistance options. Qualifying patients are eligible for the Hospital's Financial Assistance Policy based on the below criteria:

C.1. Hospital Financial Assistance through the Health Safety Net

Through its participation in the Massachusetts Health Safety Net, the Hospital provides financial assistance to low-income uninsured and underinsured patients who are Massachusetts residents and who meet income qualifications. The Health Safety Net was created to more equitably distribute the cost of providing uncompensated care to low income uninsured and underinsured patients through free or discounted care across acute hospitals in Massachusetts. The Health Safety Net pooling of uncompensated care is accomplished through an assessment on each hospital to cover the cost of care for uninsured and underinsured patients with incomes under 300% the federal poverty level. It is the hospital's policy that all patients who receive financial assistance under the hospital's financial assistance policy includes the health safety net services as part of the uncompensated care provided to low income patients.

Through its participation in the Health Safety Net, low-income patients receiving services at the Hospital may be eligible for financial assistance, including free or partially free care for Health Safety Net eligible services defined in 101 CMR 613:00.

(a) Health Safety Net - Primary

Uninsured patients who are Massachusetts residents with verified MassHealth MAGI household Income or Medical Hardship Family income, as described in 101 CMR 613.04(1), between 0-300% of the Federal Poverty Level (FPL) may be determined eligible for Health Safety Net Eligible Services.

The eligibility period and type of services for *Health Safety Net - Primary* is limited for patients eligible for enrollment in the Premium Assistance Payment Program operated by the Health

Connector as described in 101 CMR 613.04(5)(a) and (b). Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for *Health Safety Net – Primary*.

(b) Health Safety Net – Secondary
Patients that are Massachusetts residents with primary health insurance and MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 0 and 300% of the FPL may be determined eligible for Health Safety Net Eligible Services. The eligibility period and type of services for *Health Safety Net - Secondary* is limited for patients eligible for enrollment in the Premium Assistance Payment Program operated by the Health Connector as described in 101 CMR 613.04(5)(a) and (b). Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for *Health Safety Net – Primary*.

(c) Health Safety Net - Partial Deductibles
Patients that qualify for *Health Safety Net Primary* or *Health Safety Net - Secondary* with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL may be subject to an annual deductible if all members of the Premium Billing Family Group (PBFG) have an income that is above 150.1% of the FPL. This group is defined in 130 CMR 501.0001.

If any member of the PBFG has an FPL below 150.1% there is no deductible for any member of the PBFG. The annual deductible is equal to the greater of:

1. the lowest cost Premium Assistance Payment Program Operated by the Health Connector premium, adjusted for the size of the PBFG proportionally to the MassHealth FPL income standards, as of the beginning of the calendar year; or
2. 40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL.

(d) Health Safety Net - Medical Hardship
A Massachusetts resident of any income may qualify for *Medical Hardship* through the Health Safety Net if allowable medical expenses have so depleted his or her countable income that he or she is unable to pay for health services. To qualify for *Medical Hardship*, the applicant's allowable medical expenses must exceed a specified percentage of the applicant's Countable Income defined in 101 CMR 613 as follows:

Income Level	Percentage of Countable Income
0 - 205% FPL	10%
205.1 - 305% FPL	15%
305.1 - 405%	20%
405.1 - 605% FPL	30%
>605.1% FPL	40%

The applicant's required contribution is calculated as the specified percentage of Countable Income in 101 CMR 613.05(1)(b) based on the *Medical Hardship* Family's FPL multiplied by the actual Countable Income less bills not eligible for Health Safety Net payment, for which the applicant will remain responsible. Further requirements for *Medical Hardship* are specified 101 CMR 613.05.

C.2. Hospital Additional Financial Assistance

In addition to the Health Safety Net, the hospital provides financial assistance for those patients who meet its criteria as outlined below. This financial assistance is meant to supplement and not replace other coverage for services in order to ensure the financial assistance is provided when needed. The hospital will not deny financial assistance under its financial assistance policy based on the applicant's failure to provide information or documentation unless that information or documentation is described in and necessary for the determination of financial assistance through the application form.

- Who's Income falls below 300% of the Federal Poverty Level Guidelines
- Who have applied for and have been denied Financial Assistance under the State of MA Financial Assistance Programs i.e. HSN, MH, Health Connector, 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 and being denied public financial assistance in their own state, we can also apply this discount.

D. Limitations on Charges

The hospital will not charge any individual who is eligible for assistance under its financial assistance policy for emergency and medically necessary care more than the "amount generally billed" to individuals who have insurance for such care. For this purpose the "amount generally billed" is determined using the following method:

- The amounts generally billed to insured individuals is determined by taking the total Medicare payments as computed on the Medicare cost report divided by the total Medicare charges and calculating the average discount given. The current Average Discount Percentage is 46%. Your financial responsibility is then calculated as follows:
    - Your Total Charges X Calculated Average Discount Percentage = Your Financial Responsibility

*Note: It is the policy of Holyoke Medical Center to charge all patients with and without insurance its standard rates on file with the Commonwealth of Massachusetts Centers for Health Information and Analysis. The amount ultimately collected, i.e. amount generally billed, will vary depending on the Federal, State, or hospital financial assistance program for which the patient may or may not qualify as well as the applicable terms of any contract or payment rate negotiated with the patient's insurance company. The amount ultimately collected from patients without insurance is handled on a case by case basis.

The hospital will charge any individual who is eligible for assistance under its financial assistance policy for all other care an amount less than gross charges for such care.

E. Notices & Application for Hospital Financial Assistance and Public Assistance Programs

E.1 Notices of Available Hospital Financial Assistance & Public Assistance Options

For those individuals who are uninsured or underinsured, the hospital will work with patients to assist them in applying for public assistance and/or hospital financial assistance programs that may cover some or all of their unpaid hospital bills. In order to help uninsured and underinsured individuals find available and appropriate options, the hospital will provide all individuals with a general notice of the availability of public assistance and financial assistance programs during the patient's initial in-person

registration at a hospital location for a service, in all billing invoices that are sent to a patient or guarantor, and when the provider is notified or through its own due diligence becomes aware of a change in the patient's eligibility status for public or private insurance coverage.

In addition, the hospital also posts general notices at service delivery areas where there is a registration or check-in area (including, but not limited to, inpatient, outpatient, emergency departments, and affiliated community health center locations), in Certified Application Counselor ("CAC") offices, and in general business office areas that are customarily used by Patients (e.g., admissions and registration areas, or patient financial services offices that are actively open to the public). The general notice will inform the patient about the availability of public assistance and hospital financial assistance (including MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net and Medical Hardship) as well as the location(s) within the hospital and/or the phone numbers to call to schedule an appointment with a CAC. The goal of these notices is to assist individuals in applying for coverage within one or more of these programs.

E.2. Application for Hospital Financial Assistance and Public Assistance Programs

The Hospital is available to assist patients in enrolling into a state public assistance program. These include MassHealth, the premium assistance payment program operated by the state's Health Connector, and the Children's Medical Security Plan. Based on information provided by the patient, the hospital will also identify available coverage options through its financial assistance program, including the Health Safety Net and Medical Hardship programs.

For programs other than Medical Hardship, applicants can submit an application through an online website (which is centrally located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from the hospital's certified application counselor with submitting the application either on the website or through a paper application.

For Medical Hardship, hospital will work with the patient to determine if a program like Medical Hardship would be appropriate and submit a Medical Hardship application to the Health Safety Net. It is the patient's obligation to provide all necessary information as requested by the hospital in an appropriate timeframe to ensure that the hospital can submit a completed application. If the patient is able to provide all information in a timely manner, the hospital will endeavor to submit the total and completed application within five (5) business days of receiving all necessary and requested information. If the total and completed application is not submitted within five business days of receiving all necessary information, collection actions may not be taken against the patient with respect to bills eligible for Medical Hardship.

The hospital may also assist patients with enrolling in the Health Safety Net using a presumptive determination process, which provides a limited period of eligibility. This process is conducted by hospital and community health center staff, who, on the basis of self-attestation of financial information from the patient, will deem a patient as meeting the low income patient definition and will be covered for Health Safety Net services only. Coverage will begin on the date that the provider makes the determination through the end of the following month in which the presumptive determination is made. However, coverage may be terminated sooner if the patient submits a full application as described above.

For financial assistance provided through the hospital, the following documentation is required to determine eligibility:

a) Proof of Income:
    a. Most recent Income Tax Return with W-2
    b. 3 most recent paystubs
    c. or wage and tax statements
b) Government issued picture ID
c) Denial from the State Financial Assistance Programs i.e. HSN, MH, Health Connector

The hospital will not deny financial assistance under its financial assistance policy for information or documentation unless the information or documentation is described in its financial assistance policy or application form.

E.3 Role of the Hospital Financial Counselor

The hospital will help uninsured and underinsured individuals apply for health coverage through a public assistance program (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, and the Children's Medical Security Program), and work with individuals to enroll them as appropriate. The hospital will also help patients that wish to apply for financial assistance from the hospital, which includes coverage through the Health Safety Net and Medical Hardship.

The hospital will:

a) provide information about the full range of programs, including MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, and Medical Hardship;
b) help individuals complete a new application for coverage or submit a renewal for existing coverage;
c) work with the individual to obtain all required documentation;
d) submit applications or renewals (along with all required documentation);
e) interact, when applicable and as allowed under the current system limitations, with the Programs on the status of such applications and renewals;
f) help to facilitate enrollment of applicants or beneficiaries in Insurance Programs; and
g) offer and provide voter registration assistance.

The hospital will advise the patient of their obligation to provide the hospital and the applicable state agency with accurate and timely information regarding their full name, address, telephone number, date of birth, social security number (if available), current insurance coverage options (including home, motor vehicle, and other liability insurance) that can cover the cost of the care received, any other applicable financial resources, and citizenship and residency information. This information will be submitted to the state as part of the application for public program assistance to determine coverage for the services provided to the individual.

If the individual or guarantor is unable to provide the necessary information, the hospital may (at the individual's request) make reasonable efforts to obtain any additional information from other sources. Such efforts also include working with individuals, when requested by the individual, to determine if a bill for services should be sent to the individual to assist with meeting the one-time deductible. This will occur when the individual is scheduling their services, during pre-registration, while the individual is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the

hospital. Information that the CAC obtains will be maintained in accordance with applicable federal and state privacy and security laws.

The hospital will also notify the patient during the application process of their responsibility to report to both the hospital and the state agency providing coverage of healthcare services any third party that may be responsible for paying claims, including a home, auto, or other insurance liability policy. If the patient has submitted a third party claim or filed a lawsuit against a third party, the CAC will notify the patient of the requirement to notify the provider and the state program within 10 days of such actions. The patient will also be informed that they must repay the appropriate state agency the amount of the healthcare covered by the state program if there is a recovery on the claim, or assign rights to the state to allow it to recover its applicable amount.

When the individual contacts the hospital, the hospital will attempt to identify if an individual qualifies for a public assistance program or through the hospital financial assistance program. An individual who is enrolled in a public assistance program may qualify for certain benefits. Individuals may also qualify for additional assistance based on the hospital's financial assistance program based on the individual's documented income and allowable medical expenses.

***This document can be translated upon request and without charge.**

III. Attachments/Exhibits

Copies of Patient Financial Notices (See Attached Exhibits)

a) Initial, all other billing notices
b) Posted signs as well as general flyers and other handouts (if any) regarding the availability of financial assistance
c) Award/denial notices

Example of initial statement

«Insert7»
«Insert8»
CHANGE SERVICE REQUESTED

Please contact «Insert9»
"Interpretive Services available upon request."

«LetterCode» «IMBSerialNumber»

«FullName»
«AttnLine»
«Address1»
«Address2»
«City» «State» «ZipCode»-«ZipPlus4»

PATIENT NAME		AMOUNT DUE
«Insert3»		$«Insert1»
SERVICE DATE	ACCOUNT NO.	AMOUNT ENCLOSED
«Insert38»	«Insert12»	

PLEASE SEE REVERSE SIDE FOR DETAILS

WE ACCEPT: ☐ MasterCard ☐ VISA ☐ DISCOVER

PLEASE INCLUDE YOUR ACCOUNT NUMBER WHEN MAKING PAYMENT

MAKE CHECKS PAYABLE TO: HOLYOKE MEDICAL CENTER

SEND PAYMENTS TO:
Holyoke Medical Center
a member of Valley Health Systems
ATTN: BILLING DEPT.
575 BEECH STREET
HOLYOKE, MASSACHUSETTS 01040-2296

KEEP THIS BOTTOM PORTION FOR YOUR RECORDS

Patient Name	Account Number	Admission Date	Discharge Date	Billing Date
«Insert3»	«Insert12»	«Insert2»	«Insert15»	8/12/2016

SERVICE DATE	DESCRIPTION	AMOUNT
«Insert2»-«Insert15»	«Insert35»	«Insert37»
	«Insert39»	«Insert41»
	«Insert43»	«Insert45»
	«Insert47»	«Insert49»
	«Insert51»	«Insert53»
	«Insert55»	«Insert57»
	«Insert59»	«Insert61»
	«Insert63»	«Insert65»
	«Insert67»	«Insert69»
	«Insert71»	«Insert73»
	«Insert75»	«Insert77»
	«Insert79»	«Insert81»
	«Insert83»	«Insert85»
	«Insert87»	«Insert89»
	«Insert91»	«Insert93»
	«Insert95»	«Insert97»
	«Insert99»	«Insert101»
	«Insert103»	«Insert105»
	«Insert107»	«Insert109»
	«Insert111»	«Insert113»
	«Insert115»	«Insert117»
	«Insert119»	«Insert121»

Insurance Coverage	«Insert19»	Balance Forward	$«Insert1»
		Please Pay This Amount ☞	$«Insert1»

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

Thank you for choosing «Insert24» for your healthcare needs.

If you feel this is incorrect or require any assistance in understanding this statement, please call the Business Office at «Insert9» between the hours of «Insert11», or in person between 8:30 am to 3:00 pm.

Please see back of statement for important financial assistance information.

PLEASE SEE FINANCIAL ASSISTANCE INFORMATION ON REVERSE SIDE OF THIS STATEMENT

810CSTROI01HMC100

Example of the back of all statements

Section I Change of Information
A. General Information
☐ Patient ☐ Responsible Party

Name

Address

Telephone No.

Other

Section 2 Payment Information
Bills are payable in full upon receipt

☐ ☐ ☐ 3 Digit Security Code (found on back of credit card)

CREDIT CARD #

M M Y Y

Cardholder Signature Expiration Date

B. Insurance Information
Primary Insurer
Name of Insurance Co.

Insurance Co. Address

I.D. Number

Group Name or Number

Effective Date

Cardholder Name

Relationship to Patient

Employer Name

C. Medicaid Information
Patient name

Patient Address

MASS HEALTH NUMBER

Masshealth Managed Care Plan:

Name of plan:

PATIENT ID NUMBER

Are you eligible for Health Safety Net? __Y __N

Social Security #: Date of birth:

Cardholder Signature Date

IMPORTANT

This statement is only for services billed by the hospital. You may receive separate bills for radiology services, anesthesia services, pathology services or other specialized services in addition to your physician or surgeon's billings which were associated with your recent hospital services. If you have any questions regarding any of these additional billings, please call the individual phone numbers listed on each of the billings you receive.

FINANCIAL ASSISTANCE INFORMATION

Financial Assistance such as MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, the Children's Medical Security Plan, Health Safety Net, Medical Hardship, and additional Holyoke Medical Center Financial Assistance Programs may be available. Please contact our Financial Counselors for additional information. If your last name begins with A-L call (413) 535-4723 or M-Z call (413) 534-2603. For assistance with a payment plan, please call (800) 416-6072. To view our credit and collection policy and financial assistance policy, please visit our website at www.holyokehealth.com.

IMPORTANTE

Esta declaración de cuenta es solamente para los servicios cobrados por el hospital. Usted puede recibir cobros independientes por los servicios de radiología, servicios de anestesia, servicios de patología u otros servicios especializados además de su médico o cobro de los cirujanos que se asociaron con sus recientes servicios de hospital. Si usted tiene preguntas acerca de cualquiera de estos cobros adicionales, por favor llame a los números de teléfono incluidos en cada una de la facturas que reciba.

INFORMACIÓN PARA ASISTENCIA FINANCIERA

Asistencia financiera como MassHealth, el programa Premium de asistencia de pago dirigido por el Health Connector, el Children's Medical Security plan, Health Safety Net (Free Care), Medical Hardship (Dificultades médicas) y programas de asistencia financiera parte del Holyoke Centro Medico pueden estar disponible. Para información adicional por favor póngase en contacto con nuestros asesores financieros. Si tu apellido empieza con A-L llame al (413) 535-4723 o M-Z llamar (413) 534-2603. Necesita ayuda para un plan de pago? Por favor llame al (800) 416-6072. Para ver nuestra política de crédito y cobranza y póliza de asistencia financiera, por favor visite nuestro sitio web en www.holyokehealth.com.

NEED A PHYSICIAN?

If you need FREE information about local physicians, call our Health Promotion Line 8:30 am – 4:30 pm, Monday – Friday, at 413-534-2789.

NEW HMC PATIENT PORTAL NOW AVAILABLE.....

Holyoke Medical Center now has a secure way for patients to access their hospital information online, including Lab results, Radiology reports, and upcoming appointments. The HMC Patient Portal is available by visiting our website at http://www.holyokehealth.com/HMCHealthConnect.aspx.

To enroll in the portal please review the instructions and click on the green enroll button.

Example of second statement

PATIENT NAME		AMOUNT DUE
«Insert3»		$«Insert1»
SERVICE DATE	ACCOUNT NO.	AMOUNT ENCLOSED
«Insert38»	«Insert12»	

«Insert7»
«Insert8»
CHANGE SERVICE REQUESTED

Please contact «Insert9»
"Interpretive Services available upon request."

«LetterCode» «IMBSerialNumber»

«FullName»
«AttnLine»
«Address1»
«Address2»
«City» «State» «ZipCode»-«ZipPlus4»

WE ACCEPT: ☐ MasterCard ☐ VISA ☐ DISCOVER

PLEASE SEE REVERSE SIDE FOR DETAILS

PLEASE INCLUDE YOUR ACCOUNT NUMBER WHEN MAKING PAYMENT

MAKE CHECKS PAYABLE TO: HOLYOKE MEDICAL CENTER

SEND PAYMENTS TO:
Holyoke Medical Center
a member of Valley Health Systems
ATTN: BILLING DEPT.
575 BEECH STREET
HOLYOKE, MASSACHUSETTS 01040-2296

KEEP THIS BOTTOM PORTION FOR YOUR RECORDS

Patient Name	Account Number	Admission Date	Discharge Date	Billing Date
«Insert3»	«Insert12»	«Insert2»	«Insert15»	8/11/2016

SERVICE DATE	DESCRIPTION	AMOUNT
«Insert2»-«Insert15»	«Insert35»	«Insert37»
	«Insert39»	«Insert41»
	«Insert43»	«Insert45»
	«Insert47»	«Insert49»
	«Insert51»	«Insert53»
	«Insert55»	«Insert57»
	«Insert59»	«Insert61»
	«Insert63»	«Insert65»
	«Insert67»	«Insert69»
	«Insert71»	«Insert73»
	«Insert75»	«Insert77»
	«Insert79»	«Insert81»
	«Insert83»	«Insert85»
	«Insert87»	«Insert89»
	«Insert91»	«Insert93»
	«Insert95»	«Insert97»
	«Insert99»	«Insert101»
	«Insert103»	«Insert105»
	«Insert107»	«Insert109»
	«Insert111»	«Insert113»
	«Insert115»	«Insert117»
	«Insert119»	«Insert121»

Insurance Coverage	«Insert19»	Balance Forward	$«Insert1»
		Please Pay This Amount ☞	$«Insert1»

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

Thank you for choosing «Insert24». This is a reminder regarding your balance due on your account shown above.

Please refer to the account number listed above when calling or writing regarding this account. If you have any questions please feel free to call «Insert9». A representative of «Insert24» may be contacting you to discuss this account.

Itemized bill is available upon request.

PLEASE SEE FINANCIAL ASSISTANCE INFORMATION ON REVERSE SIDE OF THIS STATEMENT

810CSTROI01HMC1

Example of third statement

PATIENT NAME		AMOUNT DUE
«Insert3»		$«Insert1»
SERVICE DATE	ACCOUNT NO.	AMOUNT ENCLOSED
«Insert38»	«Insert12»	

«Insert7»
«Insert8»
CHANGE SERVICE REQUESTED

PLEASE SEE REVERSE SIDE FOR DETAILS

WE ACCEPT: ☐ ☐ ☐

PLEASE INCLUDE YOUR ACCOUNT NUMBER WHEN MAKING PAYMENT

MAKE CHECKS PAYABLE TO: HOLYOKE MEDICAL CENTER

Please contact «Insert9»
"Interpretive Services available upon request."

«LetterCode» «IMBSerialNumber»

«FullName»
«AttnLine»
«Address1»
«Address2»
«City» «State» «ZipCode»-«ZipPlus4»

SEND PAYMENTS TO:
Holyoke Medical Center
a member of Valley Health Systems
ATTN: BILLING DEPT.
575 BEECH STREET
HOLYOKE, MASSACHUSETTS 01040-2296

KEEP THIS BOTTOM PORTION FOR YOUR RECORDS

Patient Name	Account Number	Admission Date	Discharge Date	Billing Date
«Insert3»	«Insert12»	«Insert2»	«Insert15»	8/11/2016

SERVICE DATE	DESCRIPTION	AMOUNT
«Insert2»-«Insert15»	«Insert35»	«Insert37»
	«Insert39»	«Insert41»
	«Insert43»	«Insert45»
	«Insert47»	«Insert49»
	«Insert51»	«Insert53»
	«Insert55»	«Insert57»
	«Insert59»	«Insert61»
	«Insert63»	«Insert65»
	«Insert67»	«Insert69»
	«Insert71»	«Insert73»
	«Insert75»	«Insert77»
	«Insert79»	«Insert81»
	«Insert83»	«Insert85»
	«Insert87»	«Insert89»
	«Insert91»	«Insert93»
	«Insert95»	«Insert97»
	«Insert99»	«Insert101»
	«Insert103»	«Insert105»
	«Insert107»	«Insert109»
	«Insert111»	«Insert113»
	«Insert115»	«Insert117»
	«Insert119»	«Insert121»

Insurance Coverage	«Insert19»	Balance Forward	$«Insert1»
		Please Pay This Amount	$«Insert1»

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

Thank you for choosing «Insert24». This is a reminder regarding your balance due on your account shown above.

We have previously sent you a billing notice and/or attempted telephone calls requesting your assistance in resolving your open account. The balance is now due upon receipt of this notice. If you are unable to make payment in full today, please call us at once to arrange a payment plan.

If you have any questions please call «Insert9».

Itemized bill is available upon request.

PLEASE SEE FINANCIAL ASSISTANCE INFORMATION ON REVERSE SIDE OF THIS STATEMENT

810CSTROI01HMC2

Example of fourth and final statement

PATIENT NAME		AMOUNT DUE
«Insert3»		$«Insert1»
SERVICE DATE	ACCOUNT NO.	AMOUNT ENCLOSED
«Insert38»	«Insert12»	

«Insert7»
«Insert8»
CHANGE SERVICE REQUESTED

Please contact «Insert9»
"Interpretive Services available upon request."

«LetterCode» «IMBSerialNumber»

«FullName»
«AttnLine»
«Address1»
«Address2»
«City» «State» «ZipCode»-«ZipPlus4»

WE ACCEPT: ☐ MasterCard ☐ VISA ☐ DISCOVER

PLEASE SEE REVERSE SIDE FOR DETAILS

PLEASE INCLUDE YOUR ACCOUNT NUMBER WHEN MAKING PAYMENT

MAKE CHECKS PAYABLE TO: HOLYOKE MEDICAL CENTER

SEND PAYMENTS TO:
Holyoke Medical Center
a member of Valley Health Systems
ATTN: BILLING DEPT.
575 BEECH STREET
HOLYOKE, MASSACHUSETTS 01040-2296

KEEP THIS BOTTOM PORTION FOR YOUR RECORDS

Patient Name	Account Number	Admission Date	Discharge Date	Billing Date
«Insert3»	«Insert12»	«Insert2»	«Insert15»	8/11/2016

SERVICE DATE	DESCRIPTION	AMOUNT
«Insert2»-«Insert15»	«Insert35»	«Insert37»
	«Insert39»	«Insert41»
	«Insert43»	«Insert45»
	«Insert47»	«Insert49»
	«Insert51»	«Insert53»
	«Insert55»	«Insert57»
	«Insert59»	«Insert61»
	«Insert63»	«Insert65»
	«Insert67»	«Insert69»
	«Insert71»	«Insert73»
	«Insert75»	«Insert77»
	«Insert79»	«Insert81»
	«Insert83»	«Insert85»
	«Insert87»	«Insert89»
	«Insert91»	«Insert93»
	«Insert95»	«Insert97»
	«Insert99»	«Insert101»
	«Insert103»	«Insert105»
	«Insert107»	«Insert109»
	«Insert111»	«Insert113»
	«Insert115»	«Insert117»
	«Insert119»	«Insert121»

Insurance Coverage	«Insert19»	Balance Forward	$«Insert1»
		Please Pay This Amount ☞	$«Insert1»

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

Thank you for choosing «Insert24». This is a reminder regarding your balance due on your account shown above.

Over the last several weeks, we have sent you several billing notices and/or have attempted telephone calls requesting your assistance. Failure to comply will leave us with no other recourse but to place your account with a collection agency. To prevent this action, you must remit the full balance within 10 days. If you are unable to make payment in full today, please call us at once to arrange a payment plan. If you have any questions please call «Insert9».

Itemized bill is available upon request.

PLEASE SEE FINANCIAL ASSISTANCE INFORMATION ON REVERSE SIDE OF THIS STATEMENT

810CSTROI01HMC3

Example of payment plan statement

PATIENT NAME		AMOUNT DUE
«Insert3»		$«Insert10»
SERVICE DATE	ACCOUNT NO.	AMOUNT ENCLOSED
«Insert38»	«Insert12»	

«Insert7»
«Insert8»
CHANGE SERVICE REQUESTED

Please contact «Insert9»
"Interpretive Services available upon request."

«LetterCode» «IMBSerialNumber»

«FullName»
«AttnLine»
«Address1»
«Address2»
«City» «State» «ZipCode»-«ZipPlus4»

PLEASE SEE REVERSE SIDE FOR DETAILS

WE ACCEPT: ☐ MasterCard ☐ VISA ☐ DISCOVER

PLEASE INCLUDE YOUR ACCOUNT NUMBER WHEN MAKING PAYMENT

MAKE CHECKS PAYABLE TO: HOLYOKE MEDICAL CENTER

SEND PAYMENTS TO:
Holyoke Medical Center
a member of Valley Health Systems
ATTN: BILLING DEPT.
575 BEECH STREET
HOLYOKE, MASSACHUSETTS 01040-2296

KEEP THIS BOTTOM PORTION FOR YOUR RECORDS

Patient Name	Account Number	Admission Date	Discharge Date	Billing Date
«Insert3»	«Insert12»	«Insert2»	«Insert15»	8/11/2016

SERVICE DATE	DESCRIPTION	AMOUNT
«Insert2»-«Insert15»	«Insert35»	«Insert37»
	«Insert39»	«Insert41»
	«Insert43»	«Insert45»
	«Insert47»	«Insert49»
	«Insert51»	«Insert53»
	«Insert55»	«Insert57»
	«Insert59»	«Insert61»
	«Insert63»	«Insert65»
	«Insert67»	«Insert69»
	«Insert71»	«Insert73»
	«Insert75»	«Insert77»
	«Insert79»	«Insert81»
	«Insert83»	«Insert85»
	«Insert87»	«Insert89»
	«Insert91»	«Insert93»
	«Insert95»	«Insert97»
	«Insert99»	«Insert101»
	«Insert103»	«Insert105»
	«Insert107»	«Insert109»
	«Insert111»	«Insert113»
	«Insert115»	«Insert117»
	«Insert119»	«Insert121»

Insurance Coverage	«Insert19»	Balance Forward	$«Insert1»
		Please Pay This Amount ☎	$«Insert10»

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

Listed above you will find your current balance for the account # referenced above.

Your next payment of $«Insert10» is due. Please remit your payment, and include your account # on your check or money order.

Major credit cards are also accepted by completing the payment coupon above, or calling the business office.

If you feel this is incorrect or require assistance in understanding this statement, our representatives will be more then happy to assist you.

Business Office telephone # «Insert9» Office hours: «Insert11», or in person at the cashier office Monday through Friday 8:30 – 3:00 pm.

Itemized bill is available upon request.

PLEASE SEE FINANCIAL ASSISTANCE INFORMATION ON REVERSE SIDE OF THIS STATEMENT

810CSTROI01HMC87

Example of late payment statement

PATIENT NAME		AMOUNT DUE
«Insert3»		$«Insert1»
SERVICE DATE	ACCOUNT NO.	AMOUNT ENCLOSED
«Insert38»	«Insert12»	

«Insert7»
«Insert8»
CHANGE SERVICE REQUESTED

PLEASE SEE REVERSE SIDE FOR DETAILS

WE ACCEPT: ☐ MasterCard ☐ VISA ☐ DISCOVER

PLEASE INCLUDE YOUR ACCOUNT NUMBER WHEN MAKING PAYMENT

MAKE CHECKS PAYABLE TO: HOLYOKE MEDICAL CENTER

Please contact «Insert9»
"Interpretive Services available upon request."

«LetterCode» «IMBSerialNumber»

«FullName»
«AttnLine»
«Address1»
«Address2»
«City» «State» «ZipCode»-«ZipPlus4»

SEND PAYMENTS TO:
Holyoke Medical Center
a member of Valley Health Systems
ATTN: BILLING DEPT.
575 BEECH STREET
HOLYOKE, MASSACHUSETTS 01040-2296

KEEP THIS BOTTOM PORTION FOR YOUR RECORDS

Patient Name	Account Number	Admission Date	Discharge Date	Billing Date
«Insert3»	«Insert12»	«Insert2»	«Insert15»	8/11/2016

SERVICE DATE	DESCRIPTION	AMOUNT
«Insert2»-«Insert15»	«Insert35»	«Insert37»
	«Insert39»	«Insert41»
	«Insert43»	«Insert45»
	«Insert47»	«Insert49»
	«Insert51»	«Insert53»
	«Insert55»	«Insert57»
	«Insert59»	«Insert61»
	«Insert63»	«Insert65»
	«Insert67»	«Insert69»
	«Insert71»	«Insert73»
	«Insert75»	«Insert77»
	«Insert79»	«Insert81»
	«Insert83»	«Insert85»
	«Insert87»	«Insert89»
	«Insert91»	«Insert93»
	«Insert95»	«Insert97»
	«Insert99»	«Insert101»
	«Insert103»	«Insert105»
	«Insert107»	«Insert109»
	«Insert111»	«Insert113»
	«Insert115»	«Insert117»
	«Insert119»	«Insert121»

Insurance Coverage	«Insert19»	Balance Forward	$«Insert1»
		Please Pay This Amount	$«Insert1»

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

Your scheduled payment for your account(s) listed above has not been received. If you have recently mailed your payment, please disregard this letter. If you have not yet mailed your payment, it must be received within 15 days. If unable to pay amount in full, please contact the business office at «Insert9».

Itemized bill is available upon request.

PLEASE SEE FINANCIAL ASSISTANCE INFORMATION ON REVERSE SIDE OF THIS STATEMENT

810CSTROI01HMC88

Example of the front of financial assistance flyer

Example of the back of financial assistance flyer

Notice of Availability of Financial Assistance

If you are unable to pay your bill, financial assistance may be available, including but not limited to, MassHealth, the Premium Assistance Payment Program operated by the Health Connector, the Children's Medical Security Plan, Health Safety Net, Medical Hardship and additional Holyoke Medical Center Financial Assistance.

For further information about such eligibility, please inquire at:

Holyoke Medical Center
Financial Counseling Department
First Floor
8:00am to 4:00pm
Monday through Friday
Telephone: (413) 534-2603
(413) 535-4723

Aviso de Disponibilidad de Asistencia Financiera

Si usted no puede pagar su cuenta, ayuda financiera puede estar disponible, incluyendo pero no limitado a, MassHealth, el Programa de Asistencia de Pago de Prima operado por el Health Connector, el Children's Medical Security Plan, Health Safety Net, Medical Hardship y Asistencia Financiera adicional de Holyoke Medical Center.

Para mas información sobre estos programas, por favor comuníquese con:

Holyoke Medical Center
Departamento de Consejeros Financiero
Primer Piso
8:00am to 4:00pm
Lunes a Viernes
Teléfono: (413) 534-2603
(413) 535-4723

Holyoke Medical Center

HolyokeHealth.com

Example of financial assistance posted sign. The sign measures 11" x 17" and the font size is 42.

Holyoke Medical Center

HOLYOKE MEDICAL CENTER
Notice of Availability of Financial Assistance

If you are unable to pay your bill, financial assistance may be available, including but not limited to, MassHealth, the Premium Assistance Payment Program operated by the Health Connector, the Children's Medical Security Plan, Health Safety Net, Medical Hardship, and additional Holyoke Medical Center Financial Assistance. For further information about such eligibility, please inquire at:

Holyoke Medical Center
FINANCIAL COUNSELING DEPARTMENT
First Floor
8:00 am to 4:00 pm
Monday through Friday
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HOLYOKE MEDICAL CENTER
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Holyoke Medical Center
DEPARTMENTO DE CONSEJEROS FINANCIEROS
Primer Piso
Lunes a Viernes
8:00 am a 4:00 pm
Teléfono: 413-534-2603
413-535-4723

7/16

Example of financial assistance award letter
English

August 2, 2016

"Patient Name"
"Account Number"
"Date of Service"

Dear "Patient Name" :

Holyoke Medical Center reviewed your application for Financial Assistance.

You are eligible for Financial Assistance at Holyoke Medical Center. Your eligibility period is from _____ to _____.

Holyoke Medical Center's Financial Assistance Program covers the cost of medically necessary, non-experimental inpatient and outpatient services for patient whose family income is below the 300% Federal Poverty Income Guidelines at a 54% Discount. It does not cover experimental treatments, private room differential, or other non-medically necessary services.

Holyoke Medical Center's Financial Assistance Program covers the cost of medically necessary services billed by Holyoke Medical Center and all affiliated sites. It does not cover the cost of services billed by other independent groups such as private physicians and specialty groups.

If you still need medical services when your eligibility period ends, you may reapply by contacting the Financial Counseling Office at (413) 534-2603 or (413) 535-4723. It is your responsibility to notify Holyoke Medical Center if there are any changes to your family status during your eligibility period, such as changes in your family size, income, health insurance coverage or MA residency.

If you have any questions about this decision, please call the Financial Counselors Office at (413) 534-2603 or (413) 535-4723, Monday through Friday, 8:00am to 4:00pm.

Sincerely,

[Your Name]
Financial Counselor
Holyoke Medical Center

Example of financial assistance award letter Spanish

August 2, 2016

"Nombre del Paciente"
"Numero de Cuenta"
"Fecha del Servicio"

Estimado "Nombre del Paciente" :

Holyoke Medical Center revisó su solicitud para Asistencia Financiera.

Usted es elegible para la Asistencia Financiera de Holyoke Medical Center. Su periodo de elegibilidad es desde _____ hasta _____.

El programa de Asistencia Financiera de Holyoke Medical Center cubre el costo de servicios médicamente necesarios, servicios hospitalarios y ambulatorios no experimentales para pacientes cuyo ingreso familiar es menos que el 300% de las guías del Nivel Federal de Pobreza a un 54% de descuento. No cubre tratamientos experimentales, diferencial de cuartos privado, u otros servicios no-médicamente necesarios.

El programa de Asistencia Financiera de Holyoke Medical Center cubre el costo de servicios médicamente necesarios facturados por Holyoke Medical Center y todo grupo afiliado. No cubre el costo de servicios facturados por otros grupos independientes tales como doctores privados y grupos de especialidades.

Si usted aún necesita servicios médicos cuando termine su periodo de elegibilidad, usted puede volver a solicitar comunicándose con la Oficina de Consejeros Financiero al (413) 534-2603 o (413) 535-4723. Es su responsabilidad notificar a Holyoke Medical Center si hay algún cambio en el tamaño de su familia, ingreso, cobertura de seguro médico o residencia de MA.

Si usted tiene alguna pregunta sobre esta decisión, favor de llamar a la Oficina de Consejeros Financiero al (413) 534-2603 o (413) 535-4723, de Lunes a Viernes, de 8:00am a 4:00pm.

Sinceramente,

[Your Name]
Consejero Financiero
Holyoke Medical Center

Example of financial assistance denial letter
English

August 2, 2016

"Patient Name"
"Account Number"
"Date of Service"

Dear "Patient Name" :

Holyoke Medical Center reviewed your application for Financial Assistance and found that you are ineligible due to the following reason:

__ You did not apply for State Financial Assistance and/or any Federal Assistance.

__ You have health insurance.

__ Your family income is over the 300% of the Federal Poverty Guideline.

__ You are a Massachusetts resident did not apply for State Financial Assistance.

__ You did not provide the required documentation to complete your application.
Documentation needed: _____
_____
_____
**If you submit this information within 30 days, the Hospital will reconsider your application.*

__ The hospital services you wish to receive financial assistance for are/were not medically necessary. Example: cosmetic surgery, private room differentials, and personal convenience items.

__ Other reason: _____

Sincerely,

[Your Name]
Financial Counselor
Holyoke Medical Center

Example of financial assistance denial letter Spanish

August 2, 2016

"Nombre del Paciente"
"Numero de Cuenta"
"Fecha del Servicio"

Estimado "Nombre del Paciente" :

Holyoke Medical Center reviso su solicitud de Asistencia Financiera y encontró que usted no es elegible debido a la siguiente razón:

__ Usted no solicito Asistencia Financiera del Estado y/o de cualquier Asistencia Federal.

__ Usted tiene seguro médico.

__ El ingreso de su familia esta sobre el 300% del Nivel Federal de Pobreza.

__ Usted no es residente de Massachusetts y no solicito Ayuda Financiera del Estado.

__ Usted no proveyó la documentación necesaria para completar su solicitud.
Documentación necesaria: _____
_____
_____

**Si envía esta información dentro de los 30 días, el Hospital reconsiderará su solicitud.*

__ Los servicios hospitalarios para los que usted desea recibir asistencia financiera no son/eran medicamente necesarios. Por ejemplo: cirugía cosmética, diferenciales de habitaciones privadas, y artículos de conveniencia personal.

__ Otras razones: _____

Sinceramente,

[Your Name]
Consejero Financiero
Holyoke Medical Center

APPROVALS

This policy was approved by the Holyoke Medical Center's Board of Directors on August 25, 2016.