

## 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](http://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 and 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	
					<input type="checkbox"/> Yes <input type="checkbox"/> No Are you homeless?
Mailing Address (if different from street address)					
/    /		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?	
Date of Birth		Gender			

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    F	Pregnant Y    N
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

## 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?	<b>Office Use Only</b> <i>Total Income</i>
Employer's Name & Address			
Number of people who work for this company: <input type="checkbox"/> under 50 <input type="checkbox"/> 51 - 200 <input type="checkbox"/> over 200 <input type="checkbox"/> Don't know			

Name of working Family Member	Amount Earned	How Often?	<b>Office Use Only</b> <i>Total Income</i>
Employer's Name & Address			
Number of people who work for this company: <input type="checkbox"/> under 50 <input type="checkbox"/> 51 - 200 <input type="checkbox"/> over 200 <input type="checkbox"/> 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 <i>Total Income</i>
Social Security	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Railroad Retirement	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Veteran's Benefits	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Retirement Funds	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Annuities	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Pensions	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Child Support	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Alimony	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Unemployment	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Workers Comp.	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Rental Income	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Trust Income	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
EAEDC	<div></div>	<div></div>	<div>Wkly / Monthly / Yr.</div>	<div></div>
Other			<div>Wkly / Monthly / Yr.</div>	<div></div>

## 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	2025 300% Family Limit
1	\$ 46,950
2	\$63,450
3	\$79,950
4	\$ 96,450
5	\$ 112,950
6	\$ 129,450
7	\$ 145,950
8	\$ 162,450

\*\*For family sizes over 8 per household, please add \$16,500 per family member over 8 to the 2025 Federal Poverty Guidelines.

**CALCULATION:**

A) 300% Family Limit: \$ \_\_\_\_\_

B) Family Income: \$ \_\_\_\_\_

C) Family Size: \_\_\_\_\_

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

If no, please call our Billing Office at 866-904-1002  
for Payment Plan options.

Your financial assistance application is effective: \_\_\_\_\_ and  
Ends: \_\_\_\_\_

ACCT #	BILLED AMNT	DISCOUNT	NEW PT BAL	fc/initials
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____