Patient Financial Services
Financial Assistance Application

Boston Children's Hospital (the "Hospital") and its Physician Foundations (the "Foundations") are committed to being resources for children in need of care, regardless of ability to pay. This Financial Assistance Application is used to evaluate assistance opportunities for all emergency and other medically necessary care provided by the Hospital and Foundations.[1] Please print out and complete all sections that apply.

The Hospital and Foundations will work with patients to apply for public assistance (e.g. Medicaid, Commonwealth Care, and Health Safety Net) as appropriate. Failure to apply for public assistance for which you may qualify may result in the denial of your financial assistance application by the Hospital and the Foundations.

If you have any questions completing this application, please contact the Financial Counseling Unit of the Patient Financial Services Department in person at the Hospital located at 300 Longwood Avenue, Boston, MA, 02115, or by calling at (617) 355-7201.

Please mail completed applications to:

Boston Children's Hospital
Patient Financial Services – Financial Counseling
300 Longwood Avenue
Farley Building Room 160
Boston, MA, 02115

1. Applicant Information

Note 1: Applicant is the name of person completing application.

Applicant Name (First, Middle, Last)	
Applicant Relationship to Patient	
Patient's Boston Children's Medical Record Number	
Date(s) of Service for Requested Financial Assistance	
Account Number(s) for Requested Financial Assistance	
Dollars Requested	

2. Patient and Patient Guarantor Information

Note 2: Patient is the person the application is for; the person who received/ing medical care.
Note 3: Patient Guarantor is the person financially responsible for the bill.

[1] The Boston Children's Hospital Financial Assistance Policy does not apply to Boston Children's Health Solutions, Rx, LLC d/b/a Boston Children's Pharmacy or any items provided by Boston Children's Health Solutions, Rx, LLC d/b/a Boston Children's Pharmacy.

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Patient Name (First, Middle, Last)	
Patient Date of Birth	
Patient Social Security Number (if issued)	
Patient Address	☐ Own ☐ Rent ☐ Not Applicable
Patient Phone Number	
Patient Guarantor Name	
Patient Guarantor Address	
Patient Guarantor Relationship to Patient	
Patient Guarantor Employer	
Patient Guarantor Employer Address	

- Please include verification of residence such as driver's license, mortgage statement, rental agreement, tax bill, electric bill, utility bill, or phone bill.

Did the patient apply for public assistance such as Medicaid, Commonwealth Care, or Health Safety Net?

☐ Yes ☐ No ☐ Unknown Results _____

If Yes, Please provide results of the application.
If patient had public assistance on the date of service, please supply public assistance information with application.
If public assistance has previously been denied, please supply denial information.

Did the patient have health insurance on the date of service?

☐ Yes ☐ No ☐ Unknown Health Insurance _____

If patient had insurance on the date of service, please supply insurance information with application.

Does the patient / guarantor have access to health insurance through their employer?

☐ Yes ☐ No ☐ Unknown Employer _____

Did the patient / guarantor voluntarily terminate insurance within the last 60 days?

☐ Yes ☐ No ☐ Unknown Insurance_____

Does the patient have access to additional funding to help pay for medically necessary services

☐ Yes ☐ No ☐ Unknown Funding Source _____

Did the patient have a lawsuit, settlement, or liability claim pending against the date of service?

☐ Yes ☐ No ☐ Unknown Results _____

If patient had an outstanding lawsuit, settlement, or liability claim pending, please supply status with application.

3. Family Information

The Hospital determines eligibility for financial assistance programs based on the patient's family income. Discount rates are determined using the Federal Poverty Guidelines (FPG). List the patient and the patient's parent(s) and legal guardian(s) below (whether or not they live with the patient). Also list all of the patient's family members living with the patient, including the patient's siblings under age 18 living with the patient. If the patient is married, list the patient's spouse. If more than 6 members, please add supplemental paper.

Number of Family Members	

ID	Family Member Name (First, Middle, Last)	Relationship to Patient	Date of Birth	Age
1				
2				
3				
4				
5				
6				

4. Family Income

List all gross family income for the 6 and 12 month periods prior to the date of service to which this request for financial assistance relates. Gross family income is pre-tax and includes wages, unemployment compensation, workers compensation, and a number of other forms of income. Family income should be listed for the patient, the patient's parent(s) and legal guardian(s) (whether or not they live with the patient), and the patient's siblings under age 18 living with the patient. If the patient is married, family income should include the patient's spouse. Multiple sources may be listed for each income type.

Family Income Type	Family Member(s) Source(s)	Last 6-Months Gross Dollars	Last 12-Months Gross Dollars
Wages			
Unemployment Compensation			
Workers Compensation			
Public Assistance			
Pension / Retirement			
Rental Property			
Disability			
Child Support (if not reported in wage)			
Alimony (if not reported in wage)			
Social Security			
Dividend / Interest / Royalties			
Other			
Total			

- Please include verification of income, including either prior year tax returns, prior years W2, 4 recent pay stubs or written verification from Employer, Social Security check, Disability check, or signed affidavit claiming zero income.

5. Certification and Signature

I request the Hospital to make a determination of eligibility for financial assistance. I understand that this information is confidential and subject to verification by the Hospital. I also understand that if the information I provided is false, I may be denied financial aid and be liable for payment for the Hospital and Foundation services provided. I hereby attest that the information in this application is complete and accurate to the best of my knowledge and I understand the process and my responsibilities.

Applicant Name (First, Middle, Last)	
Signature	Date

