APPLICATION FOR FINANCIAL ASSISTANCE

TuftsMedicine Care at Home

☐ Home Healthcare ☐ Hospice Care ☐ Palliative Care

DATE OF APPLICATION _____ SOCIAL SECURITY NUMBER _____

TO BE COMPLETED BY PROVIDER

SOC _____ MEDICAL RECORD NUMBER _____

PATIENT INFORMATION

PATIENT NAME LAST _____ FIRST _____ MI _____ BIRTHDATE _____ TELEPHONE _____ MARITAL STATUS _____

PATIENT ADDRESS _____ STATE _____ ZIP _____

Are you currently receiving Medicaid? ☐ Yes ☐ No Have you ever applied for Medicaid? ☐ Yes ☐ No If yes, where? ☐ MA ☐ NH ☐ ME

Date of application _____ Do you need assistance with application for Medicaid or other insurance? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No If yes, please list employer name and address below.

_____

If you are employed, what is your gross income before taxes and after deductions? $_____ ☐ Week ☐ Month ☐ Annual

Is service rendered by us the direct result of a work related accident? ☐ Yes ☐ No

Do you receive regular income from: ☐ Unemployment compensation ☐ Pension ☐ Social Security Income
☐ Interest from bank account ☐ Supplemental Security Income (SSI)

If yes, please list AMOUNTS and SOURCES over the last 12 months: $_____

SPOUSE INFORMATION

SPOUSE NAME LAST _____ FIRST _____ MI _____ BIRTHDATE _____ TELEPHONE _____

SPOUSE ADDRESS ☐ SAME AS PATIENT _____ STATE _____ ZIP _____

Is your spouse currently employed? ☐ Yes ☐ No If yes, please list employer name and address below.

_____

If spouse is employed, what is his/her gross income before taxes and after deductions? $_____ ☐ Week ☐ Month ☐ Annual

Does your spouse receive regular income from: ☐ Unemployment compensation ☐ Pension ☐ Social Security Income
☐ Interest from bank account ☐ Supplemental Security Income (SSI)

If yes, please list AMOUNTS and SOURCES over the last 12 months: $_____

DEPENDENTS

DEPENDENT IN HOUSEHOLD FULL NAME _____ AGE _____ DEPENDENT IN HOUSEHOLD FULL NAME _____ AGE _____

DEPENDENT IN HOUSEHOLD FULL NAME _____ AGE _____ DEPENDENT IN HOUSEHOLD FULL NAME _____ AGE _____

DEPENDENT IN HOUSEHOLD FULL NAME _____ AGE _____ DEPENDENT IN HOUSEHOLD FULL NAME _____ AGE _____

I certify that all the information reported above is true to the best of my knowledge and belief. I understand that knowingly and willfully misrepresenting information provided on this form may subject me to prosecution under the laws of the Commonwealth of Massachusetts. I understand I may be responsible for payment for services rendered.

_____
SIGNATURE OF PATIENT OR PERSON RESPONSIBLE FOR CHARGES INCURRED

For more information please call 978-552-4000 and ask for patient accounts

_____
CLINICIAN NAME DATE