UMassMemorial
HealthAlliance Hospital

UMass Memorial - HealthAlliance Hospitals, Inc.
FINANCIAL ASSISTANCE
INSTRUCTIONS

Instructions:

As part of its commitment to serve, HealthAlliance Hospital, a member of the UMass Memorial Health Care System, will provide financial assistance to patients not covered by the states Health Safety Net Office, which meet certain income qualifications.

In order for us to determine if you qualify for financial assistance, we need to obtain certain financial information as outlined in this application. Failure to provide this information will result in a denial of assistance.

Please complete the Financial Assistance Application and return the application with income verifications to a Certified Application Counselor or the completed form may be mailed to the following address:

HealthAlliance Hospitals, Inc.
Patient Financial Counseling
60 Hospital Road
Leominster, MA 01453

Section 1: Patient Information

In Section 1 of the Financial Assistance Application, please complete all the information that pertains to the patient.

Section 2: Family Members

Section 2 of the Financial Assistance Application requests information regarding the person(s) that live in the same household as the patient. This should include the patient's spouse and dependent(s). If the patient is minor child please include the parent(s) and or legal guardian.

Section 3: Wages

Section 3 of the Financial Assistance Application requests information pertaining to employment income. Please indicate the dollar amount of the income each person receives. Also, indicate if the dollar amount is received weekly, biweekly or monthly.

Section 4: Other Income

Section 4 of the Financial Assistance Application requests information that pertains to income not related to employment. Please indicate the family member and the type

of income each person receives. Also, indicate if the dollar amount represents weekly, biweekly, monthly or annual compensation. Examples of other income would be social security or a pension.

As a condition of this application**,** verification of **All INCOME** in section 3 and 4 of this application is required. The following are acceptable verification:

- Copy of your last 2 most recent pay stubs.
- Copy of the most recent pension, social security, unemployment or other income benefit statement or check.
- Last 3 months of a profit and loss statement of business for a self employed applicant. Or the most recent tax returns within a 6 month period that indicates the above.
- A statement from your employer that indicates your gross weekly income.
- Copy of court decree or the payments received in the last 2 weeks for alimony and/or child support.

Section: 6 Comments/Affidavit of support: If you are unemployed and do not receive any income, please provide a statement of support. This statement should include your current circumstances such as who you live with and who helps you with basic living expenses such as shelter and food.

Section: 5 Health Insurance Information: If you or any family member are currently or will be covered by health insurance, please provide the information in this section.

For Assistance in completing this application, please contact:

Certified Application Counselor
Telephone: 978-466-2329
Email: financialcounsel@healthalliance.com

Office hours are Monday through Friday 8:30 a.m. – 4:30 p.m.