

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. 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 electric bill, utility bill, or phone bill. 	's license, mortgage statement, rental agreement, tax bill,		
Did the patient apply for public assistance such as Medicaid, Co	ommonwealth 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 s If public assistance has previously been denied, please supply			
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?							
Ye	s 🗌 No	Unknown	Insurance				
_							
Does	the patient h	ave access to addit	ional funding to help pay	y for medically	necessary services		
□vo	s \square No	Ulnknown	Eunding Source				
Ште	Yes No Unknown Funding Source						
Did +k	no nationt hav	vo a lawsuit sottlor	nent, or liability claim pe	ending against t	the date of service?		
— Dia ti	· —						
Ye	s	Unknown	Results				
If pat	ient had an o	utstanding lawsuit,	settlement, or liability c	laim pending, ¡	olease supply status with ap	plication.	
3.	. Family Info	ormation					
The	Hospital dete	ermines eligibility fo	or financial assistance pr	ograms based	on the patient's family inco	me. Discour	nt
rate	s are determi	ned using the Fede	ral Poverty Guidelines (I	FPG). List the p	atient and the patient's pa	rent(s) and l	egal
					f the patient's family mem		
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.							
Nun	nber of Famil	y Members					
ID		Family Member N	ame (First, Middle, Last))	Relationship to Patient	Date of	Age
1						Birth	
2							
3							
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