Franciscan Children's
So every kid can.

FINANCIAL ASSISTANCE APPLICATION

You may complete this application to apply for financial assistance to pay Franciscan Children's medical bills. Franciscan Children's will use the information you provide with your application, and any additional information required by Franciscan Children's, to evaluate your eligibility for financial assistance. Financial assistance determinations will be made at the sole discretion of Franciscan Children's within two weeks of receiving a completed Financial Assistance Application and any required supporting documents.

Patients are strongly recommended to apply for any available government assistance programs, like MassHealth and ConnectorCare, before applying for the Financial Assistance Program. Please let us know if you've recently applied for the Health Safety Net at another hospital. Failure to apply for a government assistance program that you potentially qualify for could result in a delay or denial of your application. If you need help applying for government assistance programs, please ask to speak with our Patient Accounts Staff at 617-254-3800 EXT 1202.

1. APPLICANT/PATIENT INFORMATION

Applicant's Full Name		**Date of Birth**	**Gender**
Address		**City**	**State & Zip Code**
Telephone Numbers	Home: (___) _____	Mobile: (___) _____	Work: : (___) _____
Patient's Name (if different from Applicant)		**Date of Birth**	**Admit/Service Date**

2. FAMILY MEMBERS

Please provide the following information for all of the people in your immediate family who live in your home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent (s), and the parent (s) children under 18 (natural or adoptive) who live in the patient's home.

Full Name of Family Members	**Relationship**	**Current Age or Date of Birth**
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

6. _____		

3. WAGES: Please provide documentation of all wages listed.

Name of Family Member	Gross Wages	Wage period reported (Circle One)
1. _____	$	Per: Week, Month, Year
2. _____	$	Per: Week, Month, Year
3. _____	$	Per: Week, Month, Year
4. _____	$	Per: Week, Month, Year
5. _____	$	Per: Week, Month, Year
6. _____	$	Per: Week, Month, Year

4. OTHER INCOME: Please provide documentation of all income listed.

Other Family Income	Family Member(s)	Gross Wages	Wage period reported (Circle One)
Social Security Payments		$	Per: Week, Month, Year
Unemployment		$	Per: Week, Month, Year
Pension Payments		$	Per: Week, Month, Year
Disability Funds		$	Per: Week, Month, Year
Veteran's Benefits		$	Per: Week, Month, Year
Child Support/Alimony		$	Per: Week, Month, Year
Worker's Comp		$	Per: Week, Month, Year
Business/Rental Income		$	Per: Week, Month, Year
Investment/Trust Income		$	Per: Week, Month, Year
Other _____		$	Per: Week, Month, Year

5. FAMILY ASSETS: Please provide documentation of assets. **You do not need to list your primary residence.**

Asset	Family Member(s)	Cash Value
Bank Accounts		$
Credit Union Accounts		$
Trust Funds		$
Stocks/Bonds		$
Money Market Accounts		$
Mutual Funds		$
Commercial or investment property		$
Other _____		$

6. MEDICAL HARDSHIP INFORMATION: Only required if seeking a medical hardship exemption.
Documentation may be requested but is not required at this time.

Family Medical Expenses	Average Amount	Wage period reported (Circle One)
Medical	$	Per: Week, Month, Year
Pharmacy	$	Per: Week, Month, Year
Other Health _____	$	Per: Week, Month, Year

7. HEALTH INSURANCE INFORMATION: Please provide information on Health Insurance Coverage.

Did the patient have health insurance at the time of your service? (Circle One) YES NO			
Insurance Company Name	ID Number	Subscriber Name	Effective Date

By my signing below, I certify that everything I have stated on this application and on any attachments is true to the best of my knowledge.

I agree to provide additional documentation upon request to determine my eligibility. I am aware that falsification of any information provided may result in a denial of financial assistance.

I agree to tell the hospital of any change in my income, family size, health insurance coverage, or other information that may change my eligibility for Financial Assistance.

Signature of Applicant/Guarantor: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Before submitting, please make sure that you have completed all applicable sections of this application and have included all requested documents to verify your financial status. Incomplete applications will not be approved.

Franciscan Children's Official Use Only

FAP Approved ☐ **FAP Denied** ☐

Patient's Name: _____ **MR/Acct#** _____

Service Location: _____ **Percentage of Discount:** _____

Approved By: _____ **Date:** _____

Comments: _____

_____

_____