Sturdy Health

Patient Financial Services

Out of State Free Care

Application for financial assistance.

Sturdy Memorial Hospital is committed to be a resource for patients in need of care, regardless of the 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. Please print out application and complete all sections that apply.

Patient is required to apply for financial aid in their state of residency. If approved, Sturdy will honor the same level of benefit. Proof of this must be attached to the application. Failure to apply for public assistance for which you may qualify for may result in the denial of any financial assistance. Any approval of this request is temporary and expired 12 months from the date of approval.

If you have any questions completing this application, please contact financial counselors at last name alpha split (A-J) 508-236-8127 and (K-Z) 508-236-8128. The office is open by appointment only and located on the 1st floor, of the hospital.

Please mail or fax completed applications and all supporting verifications requested to:

Sturdy Memorial Hospital

Attn: OOSFC & Financial Counselors

P.O. BOX 2963

211 Park St,

Attleboro, MA 02703

Fax: 508-236-8134

Sturdy Health

Sturdy Hospital Application for Hospital Financial Aid

Applicant Information –
Applicant in the name of person completing the application

Applicants Name (First, Middle, Last)	
Applicant relationship to patient	
Date(s) of Service for requested financial assistance	
Dollar amount requested	

Patient and Patient Guarantor Information
Patient in the person the application is for, the person who received/ing medical care.
The Guarantor is the person financially responsible for the bill.

Patient Name (First, Middle, Last)	
Patient Date of Birth	
Patient Social Security Number (if issued)	
Patient Address full mailing address	
Do they own, rent, or homeless?	
Patient Phone Number:	
Patient Guarantor Name:	
Patient Guarantor Address:	
Patient Guarantor Relationship to patient	
Patient Guarantor Employer	
Patient Guarantor Employer Address	

If living in another country please provide a local contact and mailing address:

Local contact name and relationship:	
Local Phone Number:	
Local Address:	

Please include verification of residence such a driver's license, mortgage statements, rental agreement, tax bill, phone bill, passports excepted for out of state residents.

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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). Please list the people in your family that live with you. Include your spouse and any dependent children under age 19 that live with you. If you are applying for a child under 19, please include any brothers or sisters who lives with the child.

Name of Family Member	Date of birth:	Relationship to patient

Earned Income:
List all the gross family income for the 6 and 12 month period prior to the date of service to which this request for financial assistance relates. Gross Family income is pre-tax and includes wages from a job, unemployment compensation, workers compensations, social security benefits, and self-employment. If no income, please submit no income letter included with this application.

Type of Income	Family Member Receiving Income	Gross Amount Received	How Often Weekly, Monthly, Yearly
Alimony			
Annuities			
Child Support			
Dividend, Interest, and Royalties			
Gaming or Fishing Income			
Pension / Retirement			
Public Assistance			
Railroad Retirement			
Rental Property			
Self-employment			
Social Security Benefits			
Social Security Disability Benefits			
Trust Income			
Unemployment			
Veterans Benefits			
Wages from employment			
Workers Comp.			

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***Please include all verifications of income, including either prior year tax returns, 4 recent pay stubs or written verification from employer and/or signed affidavit of claiming zero income**	
Other Insurance and additional questions If you have health insurance, you may still be eligible for Free Care to pay for amounts such as deductibles.	
Are you covered under any health insurance policy?	Yes or No
If Yes, please provide the following information:	
Policy Holder:	
Name of Health Plan:	
Policy Number:	
Are you seeking Free Care because of work related injury?	Yes or No
Are you seeking Free Care because Of a motor vehicle accident?	Yes or No
Do you have a lawsuit or other insurance claim pending?	Yes or No
Are you a college student?	Yes or No
Do you have an application pending for any other state programs?	Yes or No
Are you currently approved for Free Care at another hospital or community health center?	Yes or No
Did the patient / guarantor voluntarily terminate insurance within the last 60 days?	Yes or No
Does the patient have access to additional funding to help pay for medically necessary services?	Yes or No
Did the patient apply for public assistance such as Medicaid or Health Safety Net in the last year?	Yes or No
Have you applied for assistance in the state you reside in?	Yes or No
If you answered yes to any of the questions above, please show proof.	

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Applicant Signature: Please read this section carefully and sign at the bottom:

I authorize my employer and my health insurer to give to this hospital or community health center information about income, health insurance premiums, co-insurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking Free Care because of an accident or other incident, and I have received money because of that accident incident from any sources, such as workers' compensation or an insurance carrier, I will repay the hospital or community health center for any medical services paid by the Free Care Pool. I give the hospital or community health center the right to collect payments from insurers for medical care as appropriate.

While I am eligible for Free Care, I agree to tell this hospital or community health center of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for Free Care.

All of this information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm by eligibility for Free Care and to administer the Free Care Pool. I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency except as stated above, without my prior approval.

I am requesting the hospital and community health center to make a determination of eligibility for financial assistance. I understand that this information is confidential and subject to verification by the hospital and community health center. 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 community health center services they provided. I hereby attest that the information on this application is complete, accurate, to the best of my knowledge and I understood the process and my responsibilities.

Applicant Name (First, Middle, Last)	
Signature:	Date:
Printed Name:	

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If you have NO INCOME of any kind, please answer all questions and sign:

No Income Affidavit, Date:

1.) I _____, am NOT working AND I have NO INCOME OF ANY KIND.
2.) The last month and year if I worked was: Month_____ Year _____
3.) I earned approximately $_____ in the last 12 months.
4.) Please circle one:
    a. I will be applying for unemployment
    b. I am waiting for a decision regarding unemployment
    c. I am not waiting for a decision regarding unemployment
5.) Please circle one:
    a. I live with _family _friends _ shelter or other _____.
    b. I live off my savings. (please provide bank statement)

All the information listed above is true to the best of my knowledge.

Signature: _____ Date:_____

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Internal use only:

Family Size _____ FPL _____200% FPL used: _____

Application Received Date: _____

Determination Date: _____

Eligibility begin date: _____ End Date: _____

Encounter(s) _____

Determined by: _____

Supervisor _____Date:_____

Awarded: Full OOS Free Care Partial OOS Free Care _____Deductible

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