Gửi các bệnh nhân,

Đính kèm bên dưới là Đơn đăng ký nhận hỗ trợ tài chính của BIDHP. Vui lòng điền vào các chỗ trống và gửi lại với các giấy tờ cần thiết. Những lá đơn không hoàn chỉnh có thể sẽ không được nhận hỗ trợ tài chính.

Hạn chót gửi lại đơn đăng ký là 240 ngày kể từ khi nhận được hóa đơn đầu tiên cho dịch vụ mà bệnh nhân yêu cầu hỗ trợ tài chính.

Beth Israel Deaconess Hospital Plymouth và các đơn vị trực thuộc luôn nỗ lực cung cấp các hỗ trợ tài chính cho những bệnh nhân cần nhu cầu chăm sóc sức khỏe và không có bảo hiểm, không đủ bảo hiểm, không thỏa mãn các điều kiện để nhận các chương trình hỗ trợ của chính phủ hoặc là không đủ khả năng chi trả cho các nhu cầu chăm sóc y tế dựa trên hoàn cảnh tài chính cá nhân của họ.

Nếu quý vị có thắc mắc gì, vui lòng liện hệ với Cố vấn tài chính qua số điện thoại nêu bên dưới.

Xin chân thành cảm ơn.

Gửi đơn đăng ký đến:

Đơn vị tư vấn tài chính
Beth Israel Deaconess Hospital Plymouth
275 Sandwich Street
Plymouth, MA 02360
508-830-2057 / 580-830-2775

Application for Financial Assistance

Please Print

Today's Date: ________________ Social Security #____________________

Medical Record Number: _____________________

Patient Name: ____

Address: ____
Street Apt. Number

_________________________________ _____________ ________________
City State Zip Code

Date of Hospital Services: _______________________ Patient Date of Birth____________________

Did the patient have health insurance or Medicaid** at the time of hospital service? Yes ☐ No ☐
If "Yes", attach a copy of the insurance card (front and back) and complete the following:

Name of Insurance Company: _____________________ Policy Number: __________________

Effective Date: ___________________ Insurance Phone Number: ________________________

**Prior to applying for financial assistance, you must have applied for Medicaid in the past 6 months and will need to show proof of denial.

Note: *Financial assistance may not apply if a Health Savings Account (HSA), Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or similar fund designated for family medical expenses has been established. Payment from any established fund is due before assistance can be provided.*

To apply for financial assistance complete the following:
List all family members including the patient, parents, children and/or siblings, natural or adopted, under the age 18 living at home.

Family Member	Age	Relationship to Patient	Source of Income or Employer Name	Monthly Gross Income
1.				
2.				
3.				
4.				

In addition to the Financial Assistance Application we also need the following documentation attached to this application:

- Current state or federal income tax returns
- Current W2
- Four most recent payroll stubs
- Four most recent checking and/or savings account statements

If these are not available, please call the Financial Counseling Unit at (508) 830-2057 or (508) 830-2775 to discuss other documentation they may provide.

By my signature below, I certify that I have carefully read the Financial Assistance Policy and Application and that everything I have stated or any documentation I have attached is true and correct to the best of my knowledge. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Applicant's Signature: ______________________________ ______________________________

Relationship to Patient: ____

Date Completed: _______________________

If your income is supplemented in any way or you reported $0.00 income on this application, have the Support Statement below completed by the person(s) providing help to you and your family.

Support Statement

I have been identified by the patient/responsible party as providing financial support. Below is a list of services and support that I provide.

____

____

____

____

____

____

____

I hereby certify and verify that all of the information given is true and correct to the best of my knowledge. I understand that my signature will not make me financially responsible for the patient's medical expenses.

Signature: ____ Date Completed: ________________________

Please allow 30 days from the date the completed application is received for eligibility determination.
If eligible, financial assistance is granted for six months from the date of approval and is valid for all Beth Israel Deaconess affiliates:

Beth Israel Deaconess Medical Center-Boston
Beth Israel Deaconess Milton
Beth Israel Deaconess Needham
Beth Israel Deaconess Plymouth

Staff Only.
Application Received by:
BIDMC ☐
BID Milton ☐
BID Needham ☐
BID Plymouth ☐
Date Received: