MILFORD REGIONAL MEDICAL CENTER
FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

Please print out and complete all sections of the application that apply to you.
Please read all instructions before completing the application.

This application is used to evaluate your eligibility for Milford Regional Medical Center financial assistance.

Milford's Financial Assistance Program is generally limited to:

(1) Emergent Care
(2) Urgent Care and
(3) Short-term medically necessary care provided to patients without insurance coverage

Milford's Financial Assistance Program is not intended to cover non-urgent and non-emergency related care. It is also not intended to provide discounts on insurance co-payments, co-insurance or deductibles.

Patients are strongly encouraged to apply for any available government assistance programs, such as MassHealth, ConnectorCare or Health Safety Net, before applying for Milford's Financial Assistance Program. **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, one of our Financial Counselors can help.

If you have any questions on this application, please contact Patient Financial Services or call 508-473-1190, #8. Office hours are 8:30am-4:30pm.

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Application checklist

- ❑ Complete all applicable sections of the application – a section will indicate if it can be left blank.

- ❑ Include a copy of your driver's license, other photo identification or documents that verify your current residence. Anything submitted must include your name (Section 1).

- ❑ Include some form of income verification (Section 3 and Section 4):
  - Include a copy of your most recent IRS 1040 or 1040A
  - Unemployment
  - Social Security
  - Veteran's Benefits
  - Annuities and Pensions
  - Child Support & Alimony
  - Rental Income
  - Workers Compensation
  - Dividend & Interest Income
  - Other

- ❑ All lines on the form must be completed. If a line does not apply to you, put a line through it so we know you have not overlooked it.

- ❑ Be sure to include the signature and date for the applicant and co-applicant, if there is one.

- ❑ Return completed applications directly to one of the Milford's Patient Financial Counselors OR mail to:

Milford Regional Medical Center
Patient Financial Services
14 Prospect Street
Milford, MA 10757

To ensure prompt review of your application, please complete all sections unless otherwise indicated. The processing of the application will be delayed if you are missing required information or documentation.

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1. BASIC INFORMATION

Please complete this section about the applicant. The applicant is either the patient or the person who is financially responsible for the patient.

DOCUMENTATION REQUIRED: Please include documentation that verifies residency: driver's license, other photo identification or documents that prove your current residence. Anything submitted must include your name.

Last name	**First name**	**MI**

Date of birth	**Gender** Male ❑ Female ❑
Telephone numbers Home: ( ) Work ( ) Cell: ( )	**Mailing address** (include city, state and zip code)
Patient's name ***(if different from applicant)***	**Patient's dates of service**
Patient's date of birth ***(if different from applicant)***	**Patient's Medical Record Number** (MRN)

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2. FAMILY INFORMATION

If applicable, please list the applicant's spouse and children under 19 who live with the applicant. This section can be left blank if the applicant does not live with a spouse or children.

Name of Family Member	Relationship	Date of Birth

3. EARNED INCOME

Please complete this section about earned income for applicant and each household member listed in Section 2 who works. **Please list gross income, which is income before taxes and deductions.** This section can be left blank if the applicant and his/her household members do not have any earned income.

DOCUMENTATION REQUIRED: Please include documentation that verifies this income: pay stubs, income taxes, W2 statements, bank statements or other proof. See Page 2 for complete listing.

Name of working family member	Employer name and address	Gross amount earned	How often *check one*	Facility use only
			☐ Weekly ☐ Monthly ☐ Yearly	
			☐ Weekly ☐ Monthly ☐ Yearly	
			☐ Weekly ☐ Monthly ☐ Yearly	
			☐ Weekly ☐ Monthly ☐ Yearly	

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4. OTHER INCOME

Please complete this section about other income for the applicant and each household member listed in Section 2 who receives other income. Other income is money you receive that does not come from an employer. **Please list gross income, which is income before taxes and deductions.** This section can be left blank if the applicant and his/her household members do not have any other income.

DOCUMENTATION REQUIRED: Please include documentation that verifies this income: pay stubs, income taxes, W2 statements, bank statements or other proof. See Page 2 for complete listing.

Type of income	Family member(s) receiving income	Gross amount received	How often *circle one*	Facility use only
Unemployment			Weekly, Monthly, Yearly	
Social Security			Weekly, Monthly, Yearly	
Veteran's Benefits			Weekly, Monthly, Yearly	
Annuities and Pensions			Weekly, Monthly, Yearly	
Child Support & Alimony			Weekly, Monthly, Yearly	
Rental income			Weekly, Monthly, Yearly	
Workers Compensation			Weekly, Monthly, Yearly	
Dividend & Interest Income			Weekly, Monthly, Yearly	
Other			Weekly, Monthly, Yearly	

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5. AUTHORIZATION

Please read this section carefully and sign at the bottom.

All information in this application is true to the best of my knowledge. I agree to provide additional documentation upon request. **I understand that this confidential information cannot be disclosed to any party outside of Milford Regional Medical Center without my prior approval**.

Signature of applicant _____ Date _____

If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.

Signature of authorized representative _____ Date _____

Name of authorized representative _____ Relationship to applicant _____

Contact phone number _____

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