SOUTHCOAST HEALTH FINANCIAL ASSISTANCE APPLICATION

This Application is used to evaluate your eligibility for financial assistance with medical bills from Southcoast Health, including Southcoast Hospitals Group, Inc. (and its St. Luke's Hospital, Charlton Memorial Hospital, and Tobey Hospital campuses), Southcoast Physicians Group, Inc. and the Southcoast Visiting Nurse Association, Inc. You must must complete each section on this form, sign, and submit to Southcoast Health's Patient Financial Assistance office. You can bring this form to one of the Hospital campuses listed below or you can contact us directly at 508-973-5070.

COMPLETION OF THIS APPLICATION IS NOT A SUBSTITUTE FOR APPLYING FOR A GOVERNMENT ASSISTANCE PROGRAM IF YOU QUALIFY. YOU MAY BE REQUESTED TO COMPLETE AN APPLICATION FOR A GOVERNMENT ASSISTANCE PROGRAM, AND SOUTHCOAST HEALTH CAN ASSIST YOU WITH THAT APPLICATION.

Where can I apply?

Application Date: _____

Apply in person at any of the following location: (Hours of Operation: 8:00 A.M – 4:30 P.M.)

Charlton Memorial Hospital 363 Highland Ave Fall River, Ma 02720	**St. Luke's Hospital** 101 Page Street New Bedford, Ma 02740	**Tobey Hospital** 43 High Street Wareham, Ma 02571

- ✓ **Income & Family Size Verification:**
  - **Prior Years Income Taxes (OR)**
  - **Last 2 Pay Stubs**
- ✓ **Proof of out of state residency.**
- ✓ **Social Security Number if applicable**
- ✓ **Proof of Citizenship/National Status**

1 Step: Tell us about Yourself & Household:

Site:	**Last Name:**	**First Name:**		**Middle Initial:**
Address (street, apt#):			**Town:**	**State/Zip Code:**
DOB: / /	**Cell Phone:**	**Home Phone:**	**Work Phone:**	**Marital Status:** M / S / W / D
Date of Application: / /		**Social Security #:**	**Check box off if no permanent address:** ☐	
Preferred spoken or written language?		**E-Mail:**	**# of people listed on the application (Family Size):**	
Patient's Name (if different):		**Patient's DOB:**	**Patient's Medical Record + Account Numbers:**	

Please list the number of people in your household, DOB, and social security number (optional):

Name: _____ **DOB:** _____ **S.S.:** _____

Name: _____ **DOB:** _____ **S.S.:** _____

Name: _____ **DOB:** _____ **S.S.:** _____

Name: _____ **DOB:** _____ **S.S.:** _____

2 Step: Household Information:

Applicants Employer Name:

Employer Address:

Job Title:	**Full-time/Part-time**	**Hours weekly:**	**Does anyone have Health Insurance?**
Gross Income:	**Other Income:**	**Family Income:**	**Alimony or Child Support Income:**

3 Step: Required Documentation:

Please provide documentation evidencing income, which may include the following documentation:

- ☐ **Prior Years Tax Return**
- ☐ **Medical Expenses**
- ☐ **Birth Certificate**
- ☐ **Proof of Citizenship**
- ☐ **Proof of Residency**
- ☐ **Social Security Benefits Letter**
- ☐ **Proof of Support (if applicable)**
- ☐ **Last 2 Pay Stubs**
- ☐ **Social Security Card**
- ☐ **Proof of Immigration Status**
- ☐ **Letter of Support**
- ☐ **Unemployment Benefit Letter**
- ☐ **Pension Benefit Letter**
- ☐ **Health Insurance Card**

Additional Information (e.g., provide details regarding any specific hardship claim):

4 Step: Head of Household Review & Signature:

I hereby affirm that all information in this application is true to the best of my knowledge. I agree to provide any additional information needed upon request.

I hereby authorize Southcoast Health to conduct a review on my personal and family financial status to determine my eligibility for financial assistance. I understand that submission of this application is not a guarantee of free or discounted health care, and I may be responsible of a portion of the costs of my care (or that provided to a family member). I am giving Southcoast Health permission to review this application to determine financial status and obligation.

Applicate Signation: _____ **Date:** _____