Dear Patient,

Attached is the BID-Needham Medical Hardship Application. Please fill out in its entirety and return with all required documentation. Incomplete applications may result in denial of financial assistance.

The deadline to return the application is 240 days from the first billing statement for the services which financial assistance is being requested.

Beth Israel Deaconess Hospital Needham and its affiliates are dedicated to providing financial assistance to patients who have healthcare needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay for medically necessary care based their individual financial situation.

If you have questions please contact Financial Counseling at the number listed below.

Thank you.

Return Application to:

Financial Counseling Unit
Beth Israel Deaconess Hospital Needham
148 Chestnut Street
Needham, MA 02492
781-453-3070
Financial Assistance Application for Medical Hardship

Please Print

Today’s Date: ________________________ Social Security # _____________________________

Medical Record Number: _______________________

Patient Name: ___________________________________________________________________________

Patient Date of Birth____________________

Address: _______________________________________________________________________________

Street                                                                   Apt. Number
_________________________________                 _____________             ________________

City                               State   Zip

Did the patient have health insurance or Medicaid at the time of hospital service(s)? 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: ________________________

Note: Financial assistance due to Medical Hardship 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 medical hardship 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.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>Relationship to Patient</th>
<th>Source of Income or Employer Name</th>
<th>Monthly Gross Income</th>
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In addition to the Medical Hardship Application we also need the following documentation attached to
this application:

• Current state or federal income tax returns
• Current Forms W2 and/or Forms 1099
• Four most recent payroll stubs
• Four most recent checking and/or savings account statements
• Health savings account
• Health reimbursement arrangements
• Flexible spending accounts
• Copies of all medical bills
If these are not available, please call the Financial Counseling Unit at 781-453-3070 to discuss other documentation you may provide.

List all medical debt and provide copies of bills incurred in the previous twelve months:

<table>
<thead>
<tr>
<th>Date of service</th>
<th>Place of Service</th>
<th>Amount owed</th>
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Please provide a brief explanation of why paying these medical bills will be a hardship:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

By my signature below, I certify all of the information submitted in the application is true to the best of my knowledge, information and belief.

Applicant’s Signature: _____________________________ _____________________________

Relationship to Patient: __________________________________________________________

Date Completed: ______________________

Please allow 30 days from the date the completed application is received for eligibility determination.
If eligible, assistance is granted for six months from the date of approval and is valid for all Beth Israel Lahey Health affiliates as set forth in Appendix 5 of their respective Financial Assistance Policies:

- Anna Jaques Hospital
- Addison Gilbert Hospital
- BayRidge Hospital
- Beth Israel Deaconess Medical Center-Boston
- Beth Israel Deaconess Milton
- Beth Israel Deaconess Needham
- Beth Israel Deaconess Plymouth
- Beverly Hospital
- Lahey Hospital & Medical Center, Burlington
- Lahey Medical Center, Peabody
- Mount Auburn Hospital
- New England Baptist Hospital
- Winchester Hospital

Staff Only.
Application Received by:
AJH ☐
AGH ☐
BayRidge ☐
BIDMC ☐
BID Milton ☐
BID Needham ☐
BID Plymouth ☐
Beverly ☐
LHMC ☐
LMC Peabody ☐
MAH ☐
NEBH ☐
WH ☐

Date Received: