



**APPLICATION FOR UNINSURED RELIEF**

**HARRINGTON HOSPITAL  
100 SOUTH STREET  
SOUTHBRIDGE, MA 01550**

DATE \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

PATIENT  
NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

**APPLICANT AND HOUSEHOLD MEMBERS**

NAME	RELATION	SEX	DATE OF BIRTH	SOCIAL SECURITY #

**EMPLOYMENT INFORMATION**

Please list present employer for you and all other family in household.

**NAME OF PERSON & EMPLOYER** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**CURRENT INCOME**

<u>NAME</u>	<u>TYPE OF INCOME</u>	<u>AMOUNT PER WEEK/MONTH</u>

**HEALTH OR OTHER INSURANCE**

<u>NAME</u>	<u>CARRIER NAME</u>	<u>ID#</u>

**ASSIGNMENT OF RIGHTS**

**PLEASE READ CAREFULLY AND SIGN**

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

If I am seeking Uninsured Relief because of an accident, work related injury, or other incident that I may receive money, I will repay the hospital for any medical services paid by the Uninsured Relief Program. I give this hospital the right to collect payments from insurers for medical care as appropriate. I agree to complete an application through the Mass Health program to be consideration for Mass Health, Commonwealth Care or Health Safety Net.

While I am eligible for Uninsured Relief, I agree to tell this hospital of any changes to my family status including family size, income changes, and health insurance coverage, as this could change my eligibility for the Uninsured Relief Program.



All information in this application is true to the best of my knowledge. I agree to provide documentation at time of request. I understand that Uninsured Relief is a payor of last resort.

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Signature of all applicants over 18 yrs old

Date

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Signature of Authorized Representative

Date

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Signature

Date