Harrington
HEALTHCARE SYSTEM
Compassionate Quality Care

100 South Street
Southbridge, MA 01550
(508) 765-3134

Requirements for Uninsured Hospital Assistance Programs

The following documentation is needed in order to processes the Uninsured Relief Application for Harrington Hospital. Submit you completed application, with attachments, to the above mailing address, attention Credit Department. ***Application and documentation must be received within 9 months from date of service. Dates of service beyond 9 months are not eligible for review under this program.***

1) Proof of Current Family Income that applies to you:
   - ❑ Previous year income tax returns Federal and state (self-employed)
   - ❑ Unemployment benefit checks (unemployed)
   - ❑ 2 most recent pay stubs (working and earning wages)
   - ❑ Social Security Benefit Letter (retired)
   - ❑ Pension check stub (retired or collection pension)
   - ❑ 2 most recent checks – for child support, alimony, etc.

2) Identification for all Family Members over 18 years old:
   - ❑ Driver's license or Learner's Permit
   - ❑ Passport
   - ❑ Photo ID

3) Proof of Dependents under 18 years old:
   - ❑ Birth Certificate

Please submit copies only. Copies provided will not be returned to you and will remain on file as attachments to your application.

Upon submission of your application, please allow 30 days for processing. Only complete applications will be processed. Eligibility will be based on income information you provide. Over income status may lead to a denial which will be communicated within 30 days of application receipt. You may call our office to find out income limits for this program.

For assistance in completing this application contact a
Harrington Hospital Financial Counselor at (508) 765-3180
Monday-Friday 7:30 am – 5:00 pm

Harrington HEALTHCARE SYSTEM
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Mail completed application to: **Harrington Hospital**
Credit Department
100 South Street
Southbridge, MA 01550

Application for Uninsured Relief

Last Name:	**First Name:**	**Telephone #:**

Street:	**City:**	**State:**	**Zip:**

Bills - List bills for which this application is being made. *(Please use reverse side of this application for any other accounts)*

Name of Patient	Account #	Date of Service	Dollar Amount

Earned Income – (Attach the supporting documentation)

Employee Name	Name of Employer	Wages/Frequency
		$ week / month / year
		$ week / month / year
		$ week / month / year

Unearned Income per Month – (Attach the supporting documentation)

Social Security: $	Disability: $
Unemployment Compensation: $ Date From: To:	Worker's Compensation: $ Date From: To:
Pension or Veteran's Benefit: $	Alimony/Child Support: $
Any other income: $ Source:	

Dependents: List family members living with you and supported by you: *(Please use reverse side for additional dependents)*

Name	Relationship	Date of Birth	Social Security #

ASSIGNMENT OF RIGHTS

PLEASE READ CAREFULLY AND SIGN:
I authorize my employer and my health insurer to give this hospital information about income, health insurance premiums, co-insurance, copayments, deductible 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 considered for Mass Health, Care Plus, Health Connector 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.

In compliance with the United States Code, Title 42, Section 291E, and the regulations pursuant thereto I do certify that the information I have submitted is true and factual and that this information may be verified. I also certify that the documentation of income presented with this application represents the total family income for the period of time indicated. I understand that Uninsured Relief is a payor of last resort.

HOSPITAL USE ONLY:
Rcvd Date: _____ Rcvd by: _____

Applicant over 18 years old, or Authorized Representative:

Signature: _____ Date: _____

Name of Applicant: _____

List additional bills for which this application is being made.			
Name of Patient	**Account #**	**Date of Service**	**Dollar Amount**

Dependents: List family members/others living with you and supported by you:			
Name	**Relationship**	**Date of Birth**	**Social Security #**