****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Boston Medical Center**

**Charity Care Program Application**

Patient’s Name Social Security Number Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name (if patient is a child) Social Security Number Date of Birth

|  |  |
| --- | --- |
| **Home Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Apartment or Unit #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City Sate Zip Code | **Mailing Address**  **\_\_\_\_Check if Same as Home Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Apartment or Unit #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City Sate Zip Code |

**Marital Status: ** Single **** Married  **** Divorced **** Widowed **Are you employed? ** No **** Yes **If yes, how long?** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer offers health insurance?** **** No **** Yes

|  |
| --- |
| **HOUSEHOLD MEMBERS AND HOUSEHOLD INCOME** |
| **Types of Income and Income Code** |
| Earned Income Self-Employment IncomeSocial Security Retirement  | EISESSR | Supplemental Security IncomeSocial Security Disability IncomeUnemployment Compensation | SSISSDIUC | Veteran’s AdministrationWorker’s CompensationPension or Annuity | VAWCPA | Child SupportSpousal SupportRental Income | CSSSRI |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Relationship to Applicant** | **Date of Birth** | **Age** | **Income Type by Code** | **Income Amount (Yr./Mo./Wk.)** |
|  | Self |  |  |  | $ |
|  |  |  |  |  | $ |
|  |  |  |  |  | $ |
|  |  |  |  |  | $ |
|  |  |  |  |  | $ |
|  |  |  |  |  | $ |
| **If you need additional space to include all household members, then please use the back of the form.** |

Complete the table for HOUSEHOLD MEMBERS AND HOUSEHOLD INCOME below. Provide names and income information for all persons living in your home. Please use the income codes provided to identify the type of income received for each person.

**ASSETS - Banking Information**

Checking Account: **** No **** Yes Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Balance: \_\_\_\_\_\_\_\_\_\_\_\_\_

Savings Account: **** No **** Yes Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Balance: \_\_\_\_\_\_\_\_\_\_\_\_\_

Money Market: **** No **** Yes Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Balance: \_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSETS – Housing and Property Information**

Own a home? **** No **** Yes Mortgage: $\_\_\_\_\_\_\_\_\_\_/monthly Rent/Lease? **** No **** Yes $\_\_\_\_\_\_\_\_\_\_\_\_/monthly

Own other property? **** No **** Yes Estimated Value: $\_\_\_\_\_\_\_\_\_\_\_\_ Own vehicles? **** No **** Yes How many vehicles? \_\_\_\_

**By signing below, I agree to the following statements:**

* I declare, under penalty of perjury, that the answers I have given are true and correct to the best off my knowledge.
* I will provide all verification documents required to determine my eligibility for the BMCHS Charity Program.
* I understand that if I do not qualify for the Charity Program, I will be personally liable for charges associated with the services provided by BMCHS, or I may appeal the denial decision in writing with additional documentation.

Signature of Patient (or) Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient’s Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_