

FINANCIAL ASSISTANCE APPLICATION

STEP 1: PATIENT INFORMATION

Name (last, first, middle):	Date of Birth (mm/dd/yyyy):	Gender (M/F):
Email Address:	Home Phone Number:	Cell Phone Number:
Address:	City:	State & Zip Code:
Do you have active health insurance? (Y/N)	Household Size:	Household Income (pre-tax):
Boston Heart Accession Number (if known):	Ordering Physician:	Client ID:

STEP 2: SELECT ASSISTANCE TYPE - PICK ONE OPTION

Option 1: Patient does not carry insurance

Option2: Patient does carry insurance*

Out-of-pocket costs are discounted on a sliding scale based on household size and pre-tax income is under the amount listed in the table below.

Household Size	100% Discount	90% Discount	80% Discount	70% Discount	60% Discount	40% Discount
1	\$15,060.00	\$22,590.00	\$30,120.00	\$37,650.00	\$45,180.00	\$60,240.00
2	\$20,440.00	\$30,660.00	\$40,880.00	\$51,100.00	\$61,320.00	\$81,760.00
3	\$25,820.00	\$38,730.00	\$51,640.00	\$64,550.00	\$77,460.00	\$103,280.00
4	\$31,200.00	\$46,800.00	\$62,400.00	\$78,000.00	\$93,600.00	\$124,800.00
5	\$36,580.00	\$54,870.00	\$73,160.00	\$91,450.00	\$109,740.00	\$146,320.00
6	\$41,960.00	\$62,940.00	\$83,920.00	\$104,900.00	\$125,880.00	\$167,840.00
7	\$47,340.00	\$71,010.00	\$94,680.00	\$118,350.00	\$142,020.00	\$189,360.00
8	\$52,720.00	\$79,080.00	\$105,440.00	\$131,800.00	\$158,160.00	\$210,880.00

Income values are pre-tax and based on 2024 poverty guidelines (<https://aspe.hhs.gov/poverty-guidelines>). Boston Heart uses two times the federal poverty guidelines. Some insurance carriers choose to use the federal poverty guidelines. This may disqualify some applicants for assistance.

Extenuating circumstances considered – check if applicable and provide supporting documentation:

Unemployed Deceased Spouse

*Please complete the insurance information section below and include a copy of the patient's insurance card, front and back, along with this application. Patients covered by contracted insurance carriers may not be eligible for financial assistance.

Insurance Carrier: _____ Insured: _____

Policy/Member ID: _____ Group: _____

STEP 3: PATIENT ATTESTATION

I hereby acknowledge that the above information is true. I understand that I am responsible for supplying Boston Heart with the required proof of income to verify the information provided on this form for the purposes of assessing financial need. I understand that if I do not qualify, I will be notified and Boston Heart will bill me for the services rendered.

→ Patient Signature:

Date:

STEP 4: PATIENT MUST PROVIDE INCOME DOCUMENTATION

Boston Heart must receive confirmation of patient's household income before providing patient assistance, including: wages, social security, pension/retirement, dividends/interest, rents/royalties, unemployment or worker's compensation, alimony, or other assets. **Please provide the patient's most recent form 1040 (from the patient's federal tax return) or Social Security (SSI) benefits.**

Fax completed application and all supporting documents to Boston Heart Billing Customer Care at 866.324.3929 or forward via email to PASS@bostonheart.eufoinsus.com

For Internal Use Only

Reviewed by:	Amount Due:	% Approved:	Adjusted Amount:	Denial Reason:
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