Financial Assistance Application

Dana-Farber Cancer Institute

January 2021

Patient and family information (please use the back of this form if you need more space to complete)

Today's date: _____

Please note that the approved discount will be applied to all Patient financial obligations of PFA Eligible patients effective back to 90 days prior to the date of application.

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, ZIP: _____

Phone Number: _____

Alternate Phone Number: _____

Financially Responsible Party or Parties: _____

Relationship of Financially Responsible Party or Parties to Patient:

☐ Self ☐ Parent ☐ Spouse

☐ Adult Child ☐ Sibling ☐ Other

Did the patient have health insurance at the time of services? ☐ Yes ☐ No

If yes, please attach a copy of the insurance card (front and back) and complete the following:

Name of insurance company: _____

Policy number: _____

Group number: _____

Subscriber's name: _____

Have you applied for federal or state program assistance in the past 12 months? ☐ Yes ☐ No

If no, we recommend that you speak with a DFCI Financial Counselor prior to submitting an application.

If Yes, were you approved or denied? If you were denied, please provide a copy of the denial letter.

(provide reason for denial): _____

_____

_____

_____

Please list all family members, including patient, spouse, parents, children, and siblings, living at the patient's home:

Family member name	Age	Relationship to patient
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Income: Please list all income for responsible parties including gross (pretax) wages, rental income, unemployment, Social Security benefits, pension income, child support, alimony, etc.:

Family member name	Source of income or employer	Income amount and frequency
1.		
2.		
3.		
4.		

Other responsible parties: Please indicate if there is any other person not listed above who is legally responsible for the payment of the patient's medical expenses, such as a guardian.

☐ Yes, there is another person who is legally responsible for the patient's medical expenses.

☐ No, there isn't another person who is legally responsible for the patient's medical expenses.
If yes, please complete the following section:

Name	Address	Role or relationship

Health Expenses:

Please complete this section only if your household income is more than 300% of the Federal Poverty Level.

To be eligible for financial assistance due to excessive medical expenses, your family income must be more than 300% of the U.S. Federal Poverty Guidelines and you must provide copies of medical bills from hospitals, physicians, and other allied health professionals other than from Dana-Farber showing the amount you are responsible to pay. Dana-Farber charges will be included in the calculation of your total medical expenses, but you do not need to list those expenses. Only include medical expenses incurred in the last 12 months.

Medical Expenses	Cost	Frequency: weekly, monthly, annually
Health Insurance Premium		
Hospital Bills		
Physician Bills		
Other		
Other		
Other		

Certification: By my signature below, I certify that I have carefully read this application and everything I have stated and any documentation attached is true and correct to the best of my knowledge and belief. The responsible party acknowledges that he or she is required to report any insurance changes to Dana-Farber Cancer Institute.

_____
Printed name of responsible party or parties

_____
Signature of responsible party or parties

_____
Date

INTERNAL USE ONLY – DO NOT WRITE BELOW THIS LINE.

Patient MRN#:

Check all that apply:

☐ Meets low income guidelines ☐ Uninsured ☐ Underinsured ☐ Actively insured

Total Annual Family Income	# of Family Members	Eligible Discount

☐ Excessive Medical Expenses

Financial Assistance Application approved? ☐ Yes ☐ No

Date application reviewed: _____

Reason denied: _____

_____

_____

_____

Reviewer/Signature of Financial Counselor

_____

Date: _____

Approval/Signature of Financial Counseling Supervisor

_____

Date: _____