Dear Patient,

Attached is the Anna Jaques Hospital Financial Assistance Application. Please fill out in its entirety and return with all required documentation. Incomplete applications may result in denial of financial assistance.

The deadline to return the application is 240 days from the first billing statement for the services which financial assistance is being requested.

Anna Jaques Hospital and its affiliates are dedicated to providing financial assistance to patients who have healthcare needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay for medically necessary care based their individual financial situation.

If you have questions please contact Financial Counseling at the number listed below.

Thank you.

Return Application to:

Anna Jaques Hospital
Financial Counseling Unit
25 Highland Avenue
Newburyport, Ma. 01950
978-463-1134/1123
Financial Assistance Application for Charity Care

Please Print

Today’s Date: ________________ Social Security # ______________________

Medical Record Number: ______________________

Patient Name: _______________________________________________________________________

Address: ____________________________________________________________________________

Street                                                                   Apt. Number
_________________________________                 _____________             ________________

City                               State   Zip Code

Date of Hospital Services: _______________________ Patient Date of Birth____________________

Did the patient have health insurance or Medicaid** at the time of hospital service? Yes ☐ No ☐
If “Yes”, attach a copy of the insurance card (front and back) and complete the following:

Name of Insurance Company: _____________________ Policy Number: __________________

Effective Date: ___________________ Insurance Phone Number: ________________________

**Prior to applying for financial assistance, you must have applied for Medicaid in the past 6 months and
will need to show proof of denial.

Note: Financial assistance may not apply if a Health Savings Account (HSA), Health Reimbursement Account
(HRA), Flexible Spending Account (FSA) or similar fund designated for family medical expenses has been
established. Payment from any established fund is due before assistance can be provided.

To apply for financial assistance complete the following:
List all family members including the patient, parents, children and/or siblings, natural or adopted, under
the age 18 living at home.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>Relationship to Patient</th>
<th>Source of Income or Employer Name</th>
<th>Monthly Gross Income</th>
</tr>
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In addition to the Financial Assistance Application we also need the following documentation attached to
this application:
- Current state or federal income tax returns
- Current Forms W2 and/or Forms 1099
- Four most recent payroll stubs
- Four most recent checking and/or savings account statements
- Health savings accounts
- Health reimbursement arrangements
- Flexible spending accounts
If these are not available, please call the Financial Counseling Unit at 978-463-1134/1123 to discuss other documentation they may provide.

By my signature below, I certify that I have carefully read the Financial Assistance Policy and Application and that everything I have stated or any documentation I have attached is true and correct to the best of my knowledge. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Applicant’s Signature: _____________________________ _____________________________

Relationship to Patient: __________________________________________________________

Date Completed: ______________________

If your income is supplemented in any way or you reported $0.00 income on this application, have the Support Statement below completed by the person(s) providing help to you and your family.

**Support Statement**

I have been identified by the patient/responsible party as providing financial support. Below is a list of services and support that I provide.

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

I hereby certify and verify that all of the information given is true and correct to the best of my knowledge. I understand that my signature will not make me financially responsible for the patient’s medical expenses.

Signature: _____________________________ Date Completed: ______________________

Please allow 30 days from the date the completed application is received for eligibility determination.

If eligible, financial assistance is granted for six months from the date of approval and is valid for all Beth Israel Lahey Health affiliates as set forth in Appendix 5 of their respective Financial Assistance Policies:
- Anna Jaques Hospital
- Addison Gilbert Hospital
- BayRidge Hospital
- Beth Israel Deaconess Medical Center-Boston
- Beth Israel Deaconess Milton
- Beth Israel Deaconess Needham
- Beth Israel Deaconess Plymouth
- Beverly Hospital
- Lahey Hospital & Medical Center, Burlington
- Lahey Medical Center, Peabody
- Mount Auburn Hospital
- New England Baptist Hospital
- Winchester Hospital

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<th>Staff Only.</th>
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<tr>
<td>Application Received by:</td>
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<tr>
<td>AJH</td>
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<td>AGH</td>
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<tr>
<td>BayRidge</td>
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<td>BIDMC</td>
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Date Received: