Berkshire Health Systems

Berkshire Health Systems Financial Assistance Application

This application is used to evaluate your eligibility for financial assistance on medical bills from Berkshire Health Systems providers. You can use this application to apply for help with health care bills from any of the following Berkshire Health Systems entities:

- Berkshire Medical Center
- Fairview Hospital
- North Adams Regional Hospital
- Berkshire Faculty Services Physician Practices

Berkshire Health Systems Financial Assistance is not considered a substitute for enrolling in any available health insurance program or assistance plan. While the program covers all Medically Necessary Services, discounts vary based on the location the care was provided. Please refer to the complete financial assistance policy on our website for the details on what is covered.

Failure to apply for a government assistance program that you potentially qualify for could result in a delay or denial of your application. If you need assistance applying for a government assistance program, one of our Berkshire Health Systems Certified Application Counselors may be able to help.

You must fully disclose any other coverage, third-party liability claim, motor vehicle coverage, or workers compensation coverage to be considered.

If you have any questions on this application, please contact the Lead Certified Application Counselor of Advocacy for Access at 413-447-3139.

Application Checklist

- ☐ Complete all applicable sections of the application. A section will indicate if it can be left blank
- ☐ Include income verification
- ☐ Include proof that you have applied for any government assistance you may be eligible for
- ☐ Return the completed application and verification documents by email to fapinfo@bhs1.org or by postal mail to:

  Advocacy for Access of BMC
  Attn: Financial Assistance
  510 North St Ste 8
  Pittsfield MA 01201

To ensure prompt review of your application, please complete all sections unless otherwise indicated. The processing of the application will be delayed if you are missing required information or documentation.

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1. Basic Information

Please complete this section about the applicant. The applicant is either the patient or the person who is financially responsible for the patient.

Last Name	**First Name**	**MI**
Date of Birth	**Social Security Number**	**Gender**
Telephone Numbers Home: Cell: Work:	**Mailing address** (include city, state, and ZIP code)	
Patient's Name (if different from applicant)		
Patient's Date of Birth (if different from applicant)	**Patient's Social Security Number** (if different from applicant)	

2. Family Information

If applicable, please list the applicant's spouse and children under age 19 who live with the applicant. This section can be left blank if the applicant does not live with a spouse or children.

Name of Family Member	Relationship to Applicant	Date of Birth	Social Security #

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3. Earned Income

Please complete this section about earned income for the applicant and each household member listed in Section 2 who works. **Please list gross income, which is income before taxes and deductions.** This section can be left blank if the applicant and his/her household members do not have any earned income.

Documentation Required: Please income documentation that verifies this income: pay stubs, federal income tax return, W2 statements, profit & loss statement, payroll report, or other proof. We cannot accept deposit amounts on a bank statement as proof of income.

Name of working family member	Employer name and address	Gross amount earned	How often? (i.e. weekly, monthly, etc.)
		$	
		$	
		$	

4. Unearned Income

Please complete this section about other income for the applicant and each household member listed in Section 2 who receives unearned income. Unearned income is money you receive that does not come from an employer. **Please list gross income, which is income before taxes and deductions.** This section can be left blank if the applicant and his/her household members do not have any unearned income.

Documentation Required: Please income documentation that verifies this income: federal income tax return, 1099 statements, social security benefit letters, veteran award letter, unemployment benefit letter, or other proof. We cannot accept deposit amounts on a bank statement as proof of income.

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Type of Income	Family Member(s) receiving income	Gross Amount Received	How often? (i.e. weekly, monthly, etc.)
Unemployment		$	
Social Security		$	
Veteran's Benefits		$	
Annuities and Pensions		$	
Child Support & Alimony		$	
Rental Income		$	
Workers Compensation		$	
Dividends & Interest on Investments		$	
Other: _____		$	
Other: _____		$	

5. Certification of No Income

If the applicant and his/her family members report having no income, the applicant must complete and sign this section. If any family member reported having any type of earned or unearned income, this section can be left blank.

I, the undersigned applicant, hereby certify that my household has had no income from the time period beginning _____ /_____ /_____ to present day. I understand this certification shall be used to determine what amounts I may owe on my medical bills from Berkshire Health Systems. I further understand that if Berkshire Health Systems later determines that I was receiving income during the time period listed above, I may be held responsible for paying those medical bills.

Signature of applicant

Date

Applicant name (Please Print)

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6. Authorization

Please read this section carefully and sign at the bottom.

All information in this application is true to the best of my knowledge. I agree to provide additional documentation upon request.

Signature of applicant

Date

If signing on behalf of the applicant:

Signature of authorized representative

Date

Name of authorized representative

Relationship to applicant

Contact phone number