Commonwealth Care Alliance Financial Assistance Application

This application is used to evaluate your eligibility for financial assistance on **cost-share/copays** from Commonwealth Care Alliance providers. You can use this application to apply for help with **cost-share/copay** bills from Commonwealth Care Alliance and its subsidiaries.

Commonwealth Care Alliance Financial Assistance is not considered a substitute for enrolling in any available health insurance program. Discounts are limited based on the type of services provided and the location that the care was provided.

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 Member Services at (866) 610-2273.

Application checklist

- Complete all applicable sections of the application- a section will indicate if it can be left blank.
- Include a copy of your driver's license, other photo identification or documents that verify your current residence. Anything submitted must include your name (Section 1).
- Include some form of income verification (Section 3 and Section 4).
    - Include a copy of your most recent IRS 1040 or 1040A
    - If there has been a recent change in your income, include documentation such as recent check stubs (minimum 4), unemployment statements, bank/investment statements and/or social security statements.

Return Completed application to 30 Winter Street, Boston, MA 02108 Attn: Accounts Receivable

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.

Commonwealth Care Alliance Financial Assistance Application.

1. BASIC INFORMATION

Please complete this section about the applicant.

Last Name:	**First Name:**	**MI:**
Address:	**City, State**	**Zip Code**

Phone number: Home:	**Cellular:**
Email:	
Date of Birth:	**Last 4 Digits of SS #:**
CCA Member ID#:	**Dates of Service:**

2. Earned Income

Please complete this section about earned income for the member Please list gross income, which is income before taxes and deductions. This section can be left blank if the member do not have any earned income.

DOCUMENTATION REQUIRED: Please include documentation that verifies this income: pay stubs, income taxes, W2 statements, bank statements or other proof.

Employer Name and Address	**Gross Amount Earned**	**How often:** *Circle One*	**Facility Use only**
		Weekly **Monthly** **Yearly**	

3. Other Income

Please complete this section about other income for the applicant and each household member listed in Section 2 who receives other income. Other 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 does not have any other income.

DOCUMENTATION REQUIRED: Please include documentation that verifies this income: pay stubs, income taxes, W2 statements, bank statements or other proof.

Type of Income	**Gross Amount Received**	**How often** *Circle one*	**Facility Use Only**
Unemployment		**Weekly, Monthly, Yearly**	
Social Security		**Weekly, Monthly, Yearly**	

If Applicable, please enter requested information: if any of these circumstances apply, they will be taken into consideration

Circumstance	**Date of loss**	**Date and Amount of Expense**	**Facility Use Only**
Job Loss			
Loss of housing			
Unexpected Medical Expense			

4. 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. I understand that this confidential information cannot be disclosed to any party outside of Commonwealth Care Alliance. without my prior approval.

Signature of Applicant: _____Date:_____

12/2022