Massachusetts General Hospital
Social Service Department
Lodging Program Ancillary Request

Please check one:

MGH at the Inn ☐ **When completed, fax to Pamela Nunes, ext. 6-8544. Call to confirm receipt of fax.**

MGH Beacon House ☐ **When completed, fax to Sharon Scott, (617) 643-5875. Call to confirm receipt of fax.**

Today's Date: _____ Social Worker: _____Ext._____

Patient's Name: _____ Unit Number: _____

Name of person applying for ancillary relief: _____

Relationship to patient: _____

Address: _____

Telephone # _____

Hospital Visit: ☐Prior In-patient ☐Seen In Emergency Department ☐Presently Hospitalized

Is guest an oncology patient or the family member of an oncology patient? ☐yes ☐no

Diagnosis: _____

FAMILY INCOME

Please Check Income Status: ☐employed ☐unemployed ☐Medicare ☐SSI ☐Medicaid ☐AFDC ☐other, please explain

Total amount of gross annual income: _____

Occupation if employed: _____Number of dependents: _____

Does applicant/family have a major credit card? ☐yes ☐no If yes what type: _____

Does applicant/family have any savings? ☐yes ☐no If yes, is it over $2,000? ☐yes ☐no

IF APPLICANT IS PATIENT PLEASE COMPLETE THE FOLLOWING:

Does patient have any insurance: ☐yes ☐no If yes, is housing allowance included? ☐yes ☐no

Are funds being received from other sources for medical care, transportation, and/or living expenses (such as proceeds from a community fundraiser?): ☐yes ☐no

If yes, please explain:

_____
_____
_____
_____

Please list or briefly describe other financial conditions/situations that may help determine need:

_____
_____
_____
_____
_____
_____

Have any other resources been explored? ☐yes ☐no

Can patient make partial payment? ☐yes ☐no How much on a daily basis? _____

Please note requested check-in date at the lodging facility _____

Expected departure date_____

Social Worker
comments:_____
_____
_____

Social Worker's Signature _____ Date _____

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LODGING OFFICE USE ONLY:

Guest room number: _____ Room rate: _____

Total amount to be paid by Social Service: _____

Total amount to be paid by patient: _____

Amount of assistance not to exceed: _____

Date assistance began: _____

Ending date: _____

Total actual amount subsidized _____

Fund number _____

Revised 12/11/07
Lodging Ancillary