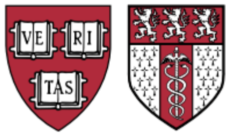


HARVARD UNIVERSITY
Health Services

Medical Hardship Fund AY2022

Harvard University Health Insurance Plan members may apply for financial support from the Harvard University Health Services Medical Hardship Fund. Members may include students (both actively registered and those on leave), affiliates, and their dependents. Please note that eligibility terms and conditions are subject to change.

Members who have graduated from Harvard and purchased the Student Health Insurance extension coverage are not eligible to apply for this fund.

To be eligible for the Hardship fund, the member:

• must an enrolled student and participating in both components of the Harvard University Student Health Program; the **Student Health Fee** and **Student Health Insurance**.
• must have their care coordinated by a Harvard University Health Services clinician.
• must be able to indicate and describe financial hardship.

The Hardship Fund can be approved for the following services:

• the allowable cost of *diagnostic/specialist visits* **beyond the twelve-visit limit** for medically necessary care not available at Harvard University Health Services (e.g., cardiology, oncology, liver, and kidney disease). ***Specialist must be an "in-network" provider. Students are still responsible for any copayments that are applied.***

• an *inpatient admission* or *outpatient surgery* when performed in a *higher cost-share hospital*, but only when the service received at the higher cost-share hospital was **non-elective** and coordinated by a Harvard University Health Services clinician when possible. In this case, a portion of the copay differential between the higher and lower cost share hospitals may be covered.

Note: The maximum amount available is up to $5,000 per academic year. Members must apply for financial support **by July 31 of the plan year for which they are requesting support.** **The Hardship fund is not available to cover the costs of health insurance or health fee premiums.*

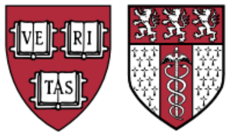
Approvals of funding will be time limited.

All information provided in the application process remains confidential and is not reflected in the patient medical record.

Procedure for Application

1. The student will be required to indicate that they are in need of financial support and to sign a release allowing the Patient Advocate to inform the Financial Aid Officer (FAO) of the request and the ultimate funding provided.
2. If funding from the Medical Hardship Fund is insufficient, the student will be advised to return to the FAO, who will assess opportunities to support the student with new or additional financial aid, or other funding sources available through the school or Committee on General Scholarship. (In cases where there is a concern about privacy or patient confidentiality, the Patient Advocate will facilitate the request as appropriate.)
3. If the student does not meet the Fund eligibility requirements, the Patient Advocate will refer the student to their FAO.
4. The cost of any services covered by the Fund will be maintained by HUHS and reported to the FAO annually

If the application is approved, the student will be required to provide denied claim information to demonstrate that a service was billed and that the insurance plan did not pay for it. The Patient Advocate will process all denied claims through BCBSMA. The patient is still responsible for any applicable visit copayments that apply.


HARVARD UNIVERSITY
Health Services

MEDICAL HARDSHIP FUND
STUDENT APPLICATION QUESTIONNAIRE

Date: ______________________________

Name: ______________________________

Address ______________________________

____

____

Phone: ______________________________

Email: ______________________________

Check One:

☐ Harvard Undergraduate Class: ____________

☐ Graduate School: Class: ________________

Name of School: __________________________

University I.D. #: _________________________

Please describe the medically necessary care that you are requesting assistance for:

Nature of Request:

Name of Outside Providers/Clinicians: (Providers must be In-Network)

Please indicate which HUHS clinician(s) you have consulted with about your care:

Estimated Cost **or** Number of Expected Visits Needed:

Please answer the following questions:

1. Do you have both the HUSHP Student Health fee and Health Insurance Plan?
   ☐ Yes ☐ No
2. Are you on a Leave of Absence? ☐ Yes ☐ No
3. Are you insured under another family member's plan as well? ☐ Yes ☐ No
4. Are you a member of the Harvard Graduate Student Union? ☐ Yes ☐ No
5. Have you already explored or secured funding assistance through this union resource? ☐ Yes ☐ No

Name of Financial Aid Officer: ____

Phone No.: ____________________________ Email Address: _________________________

ANNUAL EXPENSES:		**ANNUAL INCOME**:	
Tuition:	$____________	Work:	$____________
Books:	$____________	Spouse:	$____________
Rent:	$____________	Fellowship:	$____________
Food, etc.:	$____________	Scholarship:	$____________
Car:	$____________	Family:	$____________
Other:	$____________	Loans:	$____________
		Other (Savings):	$____________
TOTAL:	$____________	*TOTAL:*	$____________

(A) **CHILDREN**

(B) **FUND REQUEST TOTAL COST**: $____________

Number of Children: _______
Age(s): _________________

****

Use this space below if you need further space to explain any other annual expenses that impact you.

☐ I understand that this award is based on financial need and I confirm that these costs present a financial hardship for me.

I authorize Harvard University Health Services to discuss the details of this HUHS Hardship request as described above with the Financial Aid Office and the Committee on General Scholarship (if applicable) of Harvard University.

______________________________ ____________________
Signature, Student Date

Your application should include why you are applying for aid from the Hardship Fund and all relevant invoices, receipts, or treatment plans MUST be attached.
You can return the completed form to: patadvoc@huhs.harvard.edu If you prefer to send via *secure* file share, **please request this by email directly**.

All applications will be reviewed and approved by the Executive Director of Harvard University Health Services.

If you need more information or assistance in filling out this form, please contact the Patient Advocate at 617-495-7583 or via email: patadvoc@uhs.harvard.edu

To be completed by HUHS Patient Advocate.

Total amount awarded: ____________________________ Date: ______________
HUHS Hardship Fund award: _________________

Disbursement of the award is via:

- ☐ Check
- ☐ Direct payment of claims

☐ **Financial Aid Officer notified**

______________________________ ____________________
Signature, HUHS Patient Advocate Date