Medical Care- Cost Sharing Assistance

This temporary Medical Care-Cost Sharing Assistance funding has been designated by Harvard University Health Services to assist students with unexpected costs that may be creating a financial barrier to receive medical care. Considering these extraordinary circumstances, this fund can help address costs for medical care that may not be addressed with the recent benefit changes to the Student Health Insurance Plan from March 16\textsuperscript{th}-July 31\textsuperscript{st} of 2020.

When applying for these Funds, the following points should be kept in mind:

1. The funds will be granted only for out of pocket costs totaling at least $500.00 for care covered by the Student BC/BS plan.
   a. Pharmacy costs are ineligble for this fund and cannot be included in your total out of pocket costs
   b. The funds cannot not be used for students who have waived the Student BC/BS Plan.

2. The funds may be used to cover specialist/diagnostic visit copayments, outpatient mental health visit copayments, and deductible and co-insurance for covered medical services.

3. The minimum amount you must have paid out of pocket is $500.00 and the maximum amount awarded will be $1,200 to be paid for assistance per student for care administered between March 16\textsuperscript{th}-July 31\textsuperscript{st} of 2020

4. Grants will be paid only from a receipted facility/clinic billing statement.

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

6. Your application should explain why you are applying for aid, care/visit information, and include all relevant invoices and receipts.

7. If you are awarded some funding, the amount only will be shared with your school’s Financial Aid Office.

8. Return completed form to: Patient Advocate, University Health Services, 75 Mt. Auburn St. Cambridge, MA 02138.

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

Rev. 3/13/2020
UNIVERSITY HEALTH SERVICES

Medical Care-Cost Sharing Assistance

Date: ____________________________  Check One:

Name: ____________________________   [] Harvard Undergraduate
   Class ____________________________

Current Mailing Address:
   [] Radcliffe Undergraduate
   Class ____________________________

   [] Graduate School: Class ____________
   Name of School ______________________

Phone: ____________________________  University I.D. No _______________________

Email: ____________________________

☐ U.S. Citizen? _____ Yes _____ No
☐ Non-resident Alien __________________
☐ Resident alien: ________________
☐ Is on a Harvard Payroll ____________
☐ Is not on a Harvard Payroll __________

To be eligible for this funding assistance program:

• Must be enrolled in both components of the Harvard University Student Health Program
  (Student Health fee + Student Health Insurance Plan)
• The required minimum amount of out of pocket medical costs to apply for this assistance is $500.00 (Pharmacy costs are ineligible for this fund)
• The maximum amount awarded per student will be $1,200.00
• Medical Care must have occurred between March 16th - July 31st, 2020

Please list the following medical costs that you have incurred:

Date of Visit    Type of Specialty/Department    Cost of Visit Billed to You:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
To be completed by Student.

I authorize Harvard University Health Services to discuss only the award amount (if applicable) with the Financial Aid Office of Harvard University.

__________________________________________  ________________
Signature, Student                          Date

Name of Financial Aid Officer ___________________________________________________________________

Phone No. ____________________________  Email Address __________________________

Return completed form to: Patient Advocate, University Health Services, 75 Mt. Auburn St. Cambridge, MA  02138 or email patadvoc@huhs.harvard.edu

Award Confirmation (if applicable)
To be completed by HUHS and returned to FAO

Total amount awarded ___________________________ Date______________

Patient Advocate signature ___________________________ Date: ________________

Disbursement of award is via:

☐ Check