

Dear Applicant:

If payment of your health care expenses could create a financial hardship for you, please fill out this application. This application will help us determine our ability to reduce those expenses for services provided at any Dartmouth-Hitchcock or Cheshire Medical Center location. Please answer all questions that apply to you or your household. Any information you provide is confidential and is reviewed only by the staff processing your application.

If you have insurance than you may also be eligible for financial assistance with other participating providers of the NH Health Access Network. The NH Health Access Network is a network of hospitals and other health care providers that work to improve access to health care for under-insured children and adult residents of the State of New Hampshire.

Before any financial assistance is granted, you must have already exhausted all other sources of payment including insurance, public assistance, litigation, or third-party liability. Please use the checklist below to be sure you have included all the information.

	Required	N/A
1. A complete copy of your most recent Federal Income Tax Return and all schedules.	<input type="checkbox"/>	<input type="checkbox"/>
2. Copies of all most recent W-2 forms.	<input type="checkbox"/>	<input type="checkbox"/>
3. Copies of the three (3) most recent paycheck stubs or a statement from employer(s)	<input type="checkbox"/>	<input type="checkbox"/>
4. Copies of three (3) most recent bank statements (e.g., savings, checking, money Market funds, IRA, 401K, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Copies of unemployment, disability compensation benefits statements	<input type="checkbox"/>	<input type="checkbox"/>
6. Copies of social security and/or pension benefits	<input type="checkbox"/>	<input type="checkbox"/>
7. Copy of Food Stamp allocation	<input type="checkbox"/>	<input type="checkbox"/>
8. Copies of dividend sources, trust funds and property tax statements	<input type="checkbox"/>	<input type="checkbox"/>
9. Copies of government assistance notices;		
Department of Health & Human Services notices (all pages)	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid Spend Down Letters, Copies of Denial Notices from Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
Notices from Premium Assistance Plan(s) and Marketplace Insurance(s)	<input type="checkbox"/>	<input type="checkbox"/>

You can receive in person assistance completing this application at the following locations:

Dartmouth-Hitchcock Medical Center	Dartmouth-Hitchcock Concord	Dartmouth-Hitchcock Manchester	Dartmouth-Hitchcock Nashua	Cheshire Medical Center
One Medical Center Drive	253 Pleasant Street	100 Hitchcock Way	2300 Southwood Drive	580-590 Court Street
Lebanon, NH 03756	Concord, NH 03301	Manchester, NH 03104	Nashua, NH 03063	Keene, NH 03431
Local: (603) 650-6222	(603) 229-5080	(603) 695-2692	(603) 577-4055	Local: (603) 354-5430

You will continue to be financially responsible for any services you receive until your completed application is received. If you have not heard from us in 30 days after returning your application, or you need help completing the application, please call one of our Patient Advocates at (844) 647-6436.

Office hours are 9:00 a.m. – 4:30 p.m., Monday – Friday.

Completed applications should be returned to the address below.

Dartmouth Hitchcock Medical Center
 One Medical Center Dr. PFS: Level 3 FAA
 Lebanon, NH 03756
 FAX: (603) 650-6142

Cheshire Medical Center
 580-590 Court St. PFS: FAA
 Keene, NH 04431
 FAX: (603) 354-6596

Attn: PFS – Level 3 – FAA
One Medical Center Dr., Lebanon, NH 03756-0001**Financial Assistance Application****1. Patient's Information:**

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Social Security Number</i>	<i>Date of Birth</i>
<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip code</i>	<i>Length of time at address</i>
<i>Mailing Address</i>	<i>City</i>	<i>State</i>	<i>Zip code</i>	
<i>Home Phone Number</i>	<i>Work Phone Number</i>	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Civil Union
		<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
		<input type="checkbox"/> US Citizen	<input type="checkbox"/> NH Resident	

2. Person Responsible for Paying the Bill

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Relationship to Patient</i>	<i>Social Security Number</i>
<i>Address if Different From Patient's</i>	<i>Home Phone Number</i>	<i>Work Phone Number</i>		
<i>Name of Insurance Company</i>	<i>Effective Date</i>			

3. **Please indicate ALL people living in the household, including applicant: Use additional sheet of paper if needed

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOC. SECURITY#	Applying Yes/No
1	Self			
2				
3				
4				
5				
6				

4. Is this application for future or past services? Future Past Date(s) of Services: _____

5. Please fill out if anyone in your household has insurance:

Health insurance (Plan/Name) _____, Health savings account(circle) – Yes No **Who:** _____

Policy #/ID# _____ Deductible Amount: _____

Medicare Part A___, Medicare Part B___ Receives assistance to pay Medicare Part B _____ **Who:** _____6. Has anyone in your household applied for Medicaid? Yes No

Who: _____ If Yes and denied please provide copy of the Medicaid denial notice.

7. Have you applied for financial assistance at another facility? Yes No If yes, where: _____8. Is anyone in your household pregnant? Yes No9. Has anyone in your household served in the military? Yes No **Who:** _____10. Have you recently filed a workers' compensation or motor vehicle accident claim? Yes No **Date:** _____11. Is anyone in your household eligible for Social Security benefits? Yes No **Who:** _____12. Does anyone else claim you on their income tax return? Yes No **Who:** _____

13. HOUSEHOLD INFORMATION	PERSON 1	PERSON 2	PERSON 3
---------------------------	----------	----------	----------

*NAME of each household member: _____

Name of employer: _____

Gross Monthly Income From:

Employment: \$ _____ \$ _____ \$ _____

Self-Employment: \$ _____ \$ _____ \$ _____

Investment Accounts: \$ _____ \$ _____ \$ _____

Real Estate rentals: \$ _____ \$ _____ \$ _____

Unemployment: (since ___ / ___ / ___) \$ _____ \$ _____ \$ _____

Retirement: \$ _____ \$ _____ \$ _____

(Soc. Security, Pension, Annuity)

Alimony/Child Support: \$ _____ \$ _____ \$ _____

Public Assistance, Food Stamps: \$ _____ \$ _____ \$ _____

Other Income: \$ _____ \$ _____ \$ _____

Savings and Investments:

Checking Account Balances \$ _____ \$ _____ \$ _____

Savings & CD Account Balances \$ _____ \$ _____ \$ _____

IRAs, 403B, 401K: _____

Specify: _____ \$ _____ \$ _____ \$ _____

Other savings and investments: _____

Specify: _____ \$ _____ \$ _____ \$ _____

Other:

Automobile: Year, Make, Model? _____

Recreational Vehicle: Year, Make, Model? _____

14. HOUSEHOLD EXPENSES

Monthly Rent Payment: \$ _____ or Mortgage Payment: \$ _____ Mortgage Loan Balance \$ _____

Property Tax Amount Not Included in Payment Amount Above: \$ _____ Value of Home: \$ _____

Do You Own Property Other Than Primary Residence? Yes No If Yes, Value \$ _____ Mortgage balance: \$ _____

If other property is a business, list address: _____

Monthly Loan Payment: \$ _____ Paid to: _____ For: _____

Medicare Part D deducted from Social Security check: Yes No Amount: \$ _____

Utilities \$ _____ Insurance (Auto/Life/Property) \$ _____ Other: _____ \$ _____

Alimony/Child Support \$ _____ Health Insurance Premium \$ _____ Other: _____ \$ _____

Child Care \$ _____ Healthcare Bills \$ _____ Other: _____ \$ _____

Living (gas, food, clothes) \$ _____ Medications \$ _____ Other: _____ \$ _____

15. ASSIGNMENT OF RIGHTS <i>Read Carefully</i>
--

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined. In the event that I have not fully disclosed, or have inaccurately represented, any income or assets, any agreement to provide you with a charitable care discount would be null and void and would be retroactive back to the date the bills were owed. I may be liable for any/all legal fees during the collection process.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures might not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

Applicant Signature

Date

CO-Applicant Signature

Date